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THE JUNE 1955
JOURNAL
OF THE
ARKANSAS MEDICAL
SOCIETY

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VOL. LII No. 1

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The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

JUNE, 1955

No. I

Committee on Cancer Control

C. A. ARCHER, M.D., Chairman

BREAST MALIGNANCY

Currently there is much discussion over adaptation of older and the inauguration of newer methods in the treatment of cancer of the breast. There are sponsors of simple mastectomy with postoperative roentgen irradiation; of even more radical surgery and others with variations of these procedures. Radiologists have become more certain of the ability of their modality to eradicate these lesions. Surgeons have extended the scope of the classical mastectomy to include resection of the internal mammary and supraclavicular lymph nodes.

This emphasis is well and good but serves only to emphasize the extreme importance of early recognition of the disease and the institution of adequate treatment. Delay here is not always on the part of the patient. There exists no reason for "watching" these small lumps which women are more prone to discover now under the wide-spread lay educational program of the Arkansas Division, American Cancer Society.

Delay is inexcusable.

WHAT DOES THE GENERAL PRACTITIONER THINK OF PSYCHIATRY?*

E. H. CRAWFIS, Little Rock

During 1954, a survey was conducted in the State of Arkansas on the overall problem of mental health. An increasing interest in mental health, coupled with a recognition that great progress in therapy has occurred in recent years, suggested the need for an evaluation of Arkansas' mental health needs and the resources that are now available, or can be made available to meet the needs.

A Citizens' Committee was appointed to survey these needs and resources and to recommend a mental health program in the state. The medical profession was quite well represented on this Citizens' Committee, as follows: Dr. Louis Hundle, Chairman of the Council, Arkansas Medical Society; Dr. John Herron, State Health Officer; Dr. Hayden Nicholson, Dean, School of Medicine, University of Arkansas; Dr. William G. Reese, Head of the Department of Psychiatry, School of Medicine, University of Arkansas; Dr. Ewen S. Chappell, Director of Professional Education, Fort Roots Veterans Administration Hospital, and Dr. Ewing H. Crawfis, Superintendent of the Arkansas State Hospital. In addition to this representation of the medical profession by Arkansas physicians, the Committee had as its Chairman Dr. Daniel Blain, Medical Director of the American Psychiatric Association, Washington, D. C. For a part of the survey, Dr. Harvey J. Tompkins, Chief of Psychiatry, Veterans Administration, Central Office, Washington, D. C., acted in Dr. Blain's place because of the former's illness.

As a part of this survey, the Arkansas Medical Society sent a mail questionnaire prepared by the Committee to a random sample of their members. This was a pilot survey not intended to obtain statistically valid information. Forty-one responses were received, but a majority of the respondents failed to answer all of the questions, or, in a few instances answered them incorrectly. I believe that while the information is not statistically valid, it is of considerable interest and that the material is worthy of the consideration of the medical profession of the state. Accordingly, a brief discussion of selected questions and responses will be offered:

Question No. 1: In the average year, how many patients do you see in these categories: Brain disorders; psychoses; mentally defective (retarded); neuroses; psychosomatic ailments;

maladjustment problems; children's behavior problems?

The majority of the physicians saw from 1-15 per year in brain disorders, psychoses, and mentally defective categories. In the category of neuroses, the largest group of responses covered from 5-50 cases, but with a large number in the 100-500 case category. The responses of the psychosomatic ailments were fairly evenly distributed from 0 to over 500 cases. Likewise, the responses of maladjustment problems were fairly evenly distributed. The responses relating to children's behavior problems fell more in the 1-50 case group.

If we take the median figure for each category on a tabulation of responses, we obtain a profile of these responses which presumably would be representative of the number of cases seen by the average practitioner in Arkansas. This profile is as follows:

Brain disorders, 5-10 cases yearly. Psychoses, 5-10 cases yearly. Mentally defective or retarded, 10-15 cases yearly. Neuroses, 15-50 cases yearly. Psychosomatic ailments, 50-100 cases yearly. Maladjustment problems, 5-15 cases yearly. Child behavior problems, 5-15 cases yearly.

As another part of Question No. 1, it was inquired as to whether hospitalization was advised, or would be advised if available; whether psychotherapy was advised or would be advised if available; or whether psychotherapy would not be advised. The majority of physicians indicated by their responses that they recommended psychotherapy for the psychoses, but only a minority recommended it, or would recommend it if it were available, for the neuroses, psychosomatic ailments, or maladjustment problems. It seemed to me that this particular category of responses is significant and might very well bear further investigation. One might immediately ask himself "Is this because Arkansas physicians are unaware of or unconvinced of the benefits of psychotherapy?" I believe that it is generally accepted that the psychoses usually require hospitalization, but that psychotherapy in the office or out-patient clinic is the treatment of choice in the neuroses, psychosomatic ailments, and maladjustment problems.

Question No. 4 related to the hospitalization of mentally ill patients in nearby general hospitals,

*Submitted for Publication, April, 1955.

asking—"Have you hospitalized mentally ill patients in a nearby general hospital? Can the nearest general hospital be used for mental patients? Do you think it is preferable to hospitalize psychiatric patients for short-term treatment in general hospitals, or mental hospitals? Of the 34 who answered this question, 20 favored mental hospitals; 14 general hospitals. It seems to me that this distribution of responses indicates an awareness of the need for psychiatric units in general hospitals, but raises the question as to why 20 of the physicians felt mental hospitals to be preferable. It might very well be that these physicians are from rural areas where population density is not sufficiently great to justify a psychiatric unit in their general hospital.

Question No. 5 related to the referral of patients to various types of psychiatric service units, such as mental health clinics, marital counselors, child psychologists, private psychiatrists, clinical psychologists, clergymen-counselors, and Alcoholic Anonymous. Very few of the physicians seemed to have any interest in the possible contribution of the clergyman or marital counselor, or similar community facilities, other than the private psychiatrists or mental health clinics. One would immediately raise the question "Are they familiar with these auxiliary mental health facilities, or, are they generally available in the local communities in Arkansas?" One would presume that the answer to both of these questions is likely to be "No."

Question No. 7 stated "In terms of your practice and your community, what are the particular mental health needs?" The following choices were listed: Better public mental hospitals, public mental health clinics, psychiatric training courses for general practitioners, more psychiatrists in practice, more clinical psychologists in practice, training for clergymen, and other lay counselors. Only two of the respondents checked as many as three items and only two of the items were checked by a majority of the respondents. The greatest agreement was of the need for a psychiatric training course for general practitioners. Public mental health clinics, better public mental hospitals, and more psychiatrists in practice drew almost as much support, approximately one-half of the respondents checking these items. Training for clergymen and other lay counselors drew some support as approximately one-third of the respondents checked this item. These replies seem quite significant to me and merit some additional discussion. I believe that the psychiatrists in Arkansas, along with the University Medical School, should give recognition to this clearly felt need for additional training in psychiatry for the

general practitioner. This need has been expressed elsewhere and there have been efforts made to devise courses and material to meet it. The medical profession in the State of Tennessee has made considerable efforts in this field. It seems to me, therefore, that we should explore this particular situation and devise seminars and postgraduate training to meet this need.

The second comment relates to the number of favorable replies in relation to the public mental health clinics. The query immediately comes to mind "Are the Arkansas physicians willing to concede that this is not fruitful for private practice?" I would be inclined to offer this explanation of the responses, namely, that this field of medicine is one in which a very significant percentage of patients are likely to be indigent or of marginal economic status and that if the problem is to be met it will require financial support of some kind, whether this be local, state, or federal. At any rate, it appears to me on the basis of this survey that this kind of medical practice would not be objected to, nor would it encounter the criticism nor the stigma of "socialized medicine." It seems to me that this is further supported by the fact that those of our profession who have been most vocal in their criticism of the inroads of socialism have not included State Hospital practice in their objection.

In reply to a question about the role of clinical psychologists, a few favored independent practice and a few would exclude psychologists from all therapy. The bulk of the responses was divided about evenly between the other two choices: (a) Clinical psychologists accepting patients referred by general practitioners; (b) Clinical psychologists working under psychiatric supervision.

I believe that it is of interest that the Act licensing psychologists passed by the recent session of the Arkansas Legislature contemplated that clinical psychologists should conduct psychotherapy as a private practice but do so under psychiatric supervision. This would seem to be consistent with the views expressed by this survey.

The final question asked for an expression of opinion on the status of psychiatry as a medical specialty. Of the fill-in responses, 18 were favorable or neutral in character, while 14 were critical. Most of the critical responses actually implied acceptance and approval of psychiatry, but were based upon the concept that psychiatric treatment was too expensive and that the number of psychiatrists available was limited, as well as the distinct limitation upon the number of patients the average psychiatrists can treat. I believe that the implication was quite clear that the expense

was the consequence of these limiting factors, rather than that psychiatrists' fees are too expensive. Only four of the responses were directly critical of psychiatry and the psychiatrists. These statements said that the results of treatment were disappointing and that there was too much haste and too much use of shock treatment.

Out of this material, I gained the impression that there is a fairly good acceptance of the specialty of psychiatry. There is also both a recognition of the need and a desirability of expanding the psychiatric knowledge and ability of the general practitioner in order that he can deal more effectively with the large number of patients he encounters, whose illness is sufficiently mild as not to require referral to a psychiatrist.

Summary

Material from a questionnaire survey of a random sample of Arkansas physicians on mental

health problems has been presented. This material raises several issues which should be of interest to the medical profession of Arkansas: (1) Why is psychotherapy not advised or would not be advised if available in the neuroses, psychosomatic ailments, and maladjustment problems? (2) Are psychiatric units practical and economically feasible in small general hospitals serving predominantly rural areas? (3) How can we develop a community interest in and community support of some of the auxiliary mental health facilities? (4) What are the quick and practical methods by which we can carry additional training and knowledge of psychiatry to the general practitioner? (5) How can we further develop and utilize the mental health clinic approach in order to bring service to the large segment of our population which private psychiatry obviously cannot reach nor serve?

CORONARY ARTERY DISEASE**

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In the year 1949 there were 333,757 deaths in the United States attributed to arteriosclerotic or coronary heart disease. With the increasing extension of the average life expectancy, there is an increasing incidence of coronary artery disease. During the past ten years much greater effort has been expended in investigating the aetiology and control of arteriosclerosis and coronary occlusion, and much progress has been made in clarifying its pathogenesis, although the aetiology is still obscure. In Canada during the past few years, the relationship of occupation and in particular, stress, to the development of coronary thrombosis and acute coronary insufficiency has become a major problem, so much so that the Canadian Heart Association is devoting a half-day this coming June to a discussion of the question "Is ordinary effort a precipitating factor in coronary thrombosis?" Recently the Workmen's Compensation Board of the Province of Ontario called together the leading cardiologists in the Province, to point out that compensation was being awarded to so many men who had developed coronary thrombosis at or during work that employers were refusing to hire those in the age category in which this disease

might occur. It is imperative then, that although our knowledge of coronary artery disease and its consequences is still very imperfect, we must endeavor to apply such knowledge as we have in a critical and logical manner to what is a major problem in public health, in industrial medicine, and in clinical practice.

I propose to discuss the pathology of coronary artery disease and its application to the clinical syndromes of acute coronary insufficiency, and coronary occlusion.

The Morphology of Coronary Atherosclerosis

The essential fact of coronary artery disease is that it produces ischaemia by reducing the blood supply to the myocardium. There are, of course, different causes of a mechanical obstruction to the free flow of blood to the coronary arteries, for example, rare lesions such as coronary embolism, syphilitic aortitis with stenosis of coronary ostia, rheumatic arteritis, periarteritis nodosa, and thrombo-angiitis obliterans. The commonest cause, however, is sclerosis of the coronary arteries, and this means atherosclerosis.

Atheroma of coronary arteries does not differ basically from atheroma of other arteries, except that it may occur at an earlier age, and to a greater degree of severity, for reasons presently unknown.

**Given before the regular monthly meeting of the Pulaski County Medical Society, April 4, 1955.

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The earliest detectable lesion in atherosclerosis is fibrous thickening of the intima with the accumulation of foam cells and free lipid in the deeper layers of this fibrous tissue. The lesion is initially plaque-like or linear and slowly enlarges with the accumulation of more and more lipid material. As this lipid accumulates, the internal elastic lamina becomes frayed and split and eventually completely destroyed. The lipid is the same as that found in plasma, and in approximately the same ratio, that is, cholesterol, cholesterol esters, phospholipid and neutral fat.

The amount of fibrous tissue around this central mass of soft pultaceous material is variable: sometimes it forms a layer of considerable thickness separating the lipid material from the endothelium, while at other times the soft amorphous mass extends almost to the lining endothelium. By the time the lesion has seriously encroached upon the lumen of the artery the underlying media shows a variable degree of atrophy. In addition, vascularization of the plaque, which now consists of a mass of necrotic debris and lipid has developed.

This vascularization is derived from two sources: first, from the arterial lumen, and secondly, from the vasa vasorum of the adventitia. Older lesions often show foreign body reactions to cholesterol crystals, some infiltration with histiocytes and leucocytes, and not infrequently, old and recent haemorrhage. This haemorrhage is derived undoubtedly from the capillary network which appears to surround the atheroma. The old haemorrhage is evidenced by pigment-laden histiocytes and ceroid, a peculiar pigment formed from the combination of haemoglobin and lipid. Calcification of the lipoidal and necrotic material is commonly seen in late lesions. There is some evidence too that regression of atheroma does occur, in that most of the lipid may be resorbed, leaving only a fibrous plaque.

Although we do not know what initiates the formation of atheroma, it is generally accepted from the observations, experimental and otherwise, of Duff¹ and others, that there is initially an alteration in the vessel wall. The nature and cause of this change we do not know, but in experimentally produced atheroma in rabbits, the deposition of lipid is preceded by an alteration of the ground substance of the intima.

Some support for the concept of a metabolic disturbance of ground substance as a primary cause for the development of atheroma is found in diabetes mellitus and myxoedema, where endocrine deficiency causes an alteration in the mucopolysaccharides of intercellular material. There is some evidence too, that the mechanical stress

of hypertension may alter the permeability of the vessel wall. Inflammatory lesions may also predispose to the development of atheroma, as shown so clearly in syphilitic aortitis.

In recent years much prominence has been given to alterations in plasma lipids in the pathogenesis of atheroma, and I think the evidence is good that not only the level of blood lipids, but also their character may influence the progression of the lesions, once they have begun. For example, Gofman² and associates have demonstrated the presence of abnormal macromolecules of lipid-protein aggregates in those suffering from atherosclerosis, and also in experimental atherosclerosis. Duff³ and Ladd and his associates⁴ have demonstrated experimentally that the ratio of cholesterol: phospholipid; neutral fat in plasma may also influence the development of atheroma. There is too, the clinical evidence of premature and severe atherosclerosis in congenital hypercholesterolaemia. It is obvious, however, that given an elevation of lipids, or abnormal lipids, or even normal lipids, the deposition of them will only occur at points of previous injury. Otherwise, as Paterson⁵ has said, without the previous injury, the disease process should be diffusely spread throughout the arterial system instead of being focal in its distribution. We do not know why the coronary arteries are so prone to develop atheroma, but an hypothesis has been suggested by Dock to explain the localization in these vessels. The intima of coronary arteries in infants is much thicker than it is in other arteries, and in fact the thickness of the intima is three times greater in male than in female infants. This thickening also is focal in its distribution, and Dock⁶ suggests that the congenital fibrous thickening of the intima of the coronary arteries forms the sites for subsequent deposition of lipids and the development of atheroma. Dock's hypothesis would also explain the greater incidence of atherosclerosis in males than in female.

The localization of coronary sclerosis is most marked and usually earliest in the first part of the anterior descending branch of the left coronary artery, and also in the main stem of the left coronary artery, secondly in the first portion of the right coronary artery, and thirdly in the first portion of the left circumflex branch. Lastly, I should mention that there is considerable evidence that there is an hereditary factor in atherosclerosis.

The Mechanism of Coronary Thrombosis

There are several theories regarding the mechanism of thrombus formation over an atheromatous plaque. One such is that irregularity and stenosis of the lumen produced by atheroma results in eddying of blood and precipitation of

platelets, and thus thrombus formation. Leary⁷ observed defects in the intima at the site of thrombosis, with atheromatous material in the overlying thrombus, and concluded that rupture of an atheromatous plaque was the immediate cause of the thrombosis.

In 1936 J. C. Paterson⁸ studied 10 cases of recent coronary thrombosis by serial section. In 7 of these he found, at the site of thrombotic occlusion, haemorrhagic foci intimately associated with the thrombus, while in the remaining 3, although haemorrhages were present, they were not so closely related. He therefore claimed that the precipitating cause of coronary thrombosis was haemorrhage into a softened atheromatous plaque. Wartman,⁹ in 1938, studied 41 occluded coronary arteries by serial section, and found in 6 of these, an intramural haematoma which completely occluded the lumen by expansion of the atheromatous plaque, and in 14 of the other cases the combination of intramural haemorrhage and superimposed thrombus. More recently, French and Dock,¹⁰ in 1944, found haemorrhages in the atherosclerotic plaques of only 5 of 80 soldiers with fatal coronary sclerosis, while Yater¹¹ and associates encountered haemorrhage in atherosclerotic plaques in 12 percent of subjects dying suddenly from coronary artery disease. Paterson maintains that other workers have not confirmed his results because their serial sections were not close enough together. This question of intramural haemorrhage as a precipitating factor in coronary thrombosis is an exceedingly important one because Paterson maintains that elevation of systemic blood pressure through effort or emotion, or for any other reason, may cause rupture of these capillaries because they are supported only by the soft atheromatous material and are subjected to a high pressure. In this latter regard, the source of these capillaries is of importance, Paterson maintaining that they are derived from the lumen. He traced such communications with the lumen in 4 cases only. Wartman, on the other hand, and also Winternitz,¹² pointed out that many of them are derived from adventitial blood vessels. In the Department of Pathology at the University of Toronto, we have recently undertaken a study of coronary sclerosis, in order to determine the origin of the capillaries which vascularize the atherosclerotic plaque, and to determine the incidence of haemorrhage associated with thrombus. Although this study has not been under way for very long, we have to date examined 19 cases. Our method follows that described by Durlacher.¹³ The heart is removed by cutting

across the aorta a few centimeters above its origin, and then perfused through the aorta, with normal saline followed by 10 percent formalin. The heart is then fixed in 10 percent formalin for 24 hours. After fixation is complete the coronary arteries are carefully dissected free, down to the finest ramifications that can be followed. They are placed in decalcifying solution, dehydrated, and cleared in methyl benzoate. Once the arteries have been cleared it is very easy to see intimal haemorrhages and thrombi. Blocks are taken from areas of opacity and sectioned. In the 19 cases examined, we have found a total of 23 occlusions of the coronary arteries. It can be seen therefore that in some cases the occlusions were multiple. It is of interest to note that in 2 cases only the occlusion was due to a massive intimal haematoma. In 5 cases there was intimal haemorrhage with superimposed thrombus. In the remaining 16 cases no intimal haemorrhages appeared to be associated with the overlying thrombus. We also discovered, however, that intimal haemorrhages not associated with thrombosis were relatively frequent and were encountered in 11 cases apart from those described above.

We were particularly interested in trying to find the source of the capillaries, but in only 2 instances could capillaries be traced from the lumen into the atheroma. In all the rest the capillaries appeared to be derived from the adventitia, passing through greatly atrophic and thinned media, to fan out around the atheromatous plaque.

With regard to the origination of intimal capillaries derived from the lumen, there is a good possibility that they represent organization and recanalization of non-occlusive thrombi. Whatever their origin, from the lumen, or the adventitia, one must accept that rupture of these vessels does occur and that such rupture may result (1) in complete occlusion of the lumen by expansion of the atheroma, as observed by Wartman and others, or (2) in rupture of the atheroma and consequent thrombus formation.

The point at issue is how frequently is intimal haemorrhage the cause of occlusion of the lumen, either directly or by precipitating thrombus formation? Paterson maintains this is the cause in over 90 percent of cases, Wartman in 50 percent, and in our own series 25 percent.

Another observation of importance is that the thrombus frequently appears to have been built up slowly, in that histologically it is older in some areas than in others. This was noted whether or not there was an associated intimal haemorrhage, in our cases.

Myocardial Infarction

It has been well demonstrated by Schlesinger,¹⁴ Harrison,¹⁵ and others, that partial or complete occlusion of a coronary artery is followed by enlargement of pre-existing anastomotic vessels, and development of new anastomotic channels. Wiggers¹⁶ enumerated three types of compensatory anastomoses that develop: (1) intercoronary communications; (2) extracardial communications (pericardial); and (3) enlargement of arterial lumina. Schlesinger showed that a rich anastomotic circulation developed only in those hearts in which an occlusion had occurred, and represents a response to disease in the heart.

Here is the explanation then, for the facts that (1) coronary occlusion is not always followed by myocardial infarction, and (2) the size of the infarct is variable, being dependent on the extent of anastomotic circulation resulting from pre-existing coronary stenosis, and the speed of the occlusion.

Infarction will only be found when the patient has survived an attack of acute coronary insufficiency by at least 24 hours.

In our own series of cases, 19 in all, we found 23 occlusive lesions in coronary arteries, and 14 infarcts. In every case of infarction, one or more old or recent occlusions of coronary arteries were demonstrated. In other words, we did not find infarction without thrombosis. Wartman¹⁷ found thrombi, intimal haemorrhage, or sclerotic occlusion in about 90 percent of his series of cases of infarction. Karsner¹⁸ states, in the last edition of his text-book, that he has never seen infarction without organic occlusion of a coronary artery. Our experience in finding more than one occlusion confirms the findings of Saphir.¹⁹ Syphilitic aortitis provides a good example of marked narrowing of the ostia of the coronary arteries, but in our cases of syphilitic aortitis at the University of Toronto, we have not found infarction of myocardium. We have found, however, focal areas of resorption and fibrosis. These areas are microscopic in size. Buchner²⁰ has described such microscopic foci as resulting from acute or chronic deficiency of oxygen in myocardial blood supply. Beck²¹ has also described similar changes occurring in carbon monoxide poisoning and Dack²² in cases of pulmonary embolism. Master²³ and his associates demonstrated subendocardial lesions in patients suffering from acute coronary insufficiency following acute haemorrhage, particularly of the gastro-intestinal tract. Some of these lesions were grossly recognizable as confluent areas of myocardial necrosis. One must accept, I think, that infarction of heart muscle may occur in the

absence of complete occlusion of a coronary artery, but I should like to stress that such infarction is usually very limited in extent, is subendocardial in distribution, and is not comparable to the massive and full-thickness infarcts we may see following coronary thrombosis. In all such cases of infarction without occlusion, there is either marked sclerosis of coronary arteries, or hypertrophy of left ventricle due to hypertension, or both.

Sequelae of Myocardial Infarction

The consequences of myocardial infarction are many and well known, and I shall only discuss some of them briefly.

As stated earlier, the left coronary artery, or its descending branch, is occluded more often than the right, or left circumflex branches, so that, most commonly, infarction involves the left ventricle, and usually its apical portion. The right ventricle is usually only affected to a lesser degree, and as part of a large apical and septal infarct of the left ventricle. Infarcts limited to the right ventricle are rare, as are infarcts of atria.

Sudden death is usually due to a disturbance of the conducting mechanism, such as ventricular fibrillation or heart block. Shock, progressive circulatory failure and embolism may follow an attack of infarction. Pulmonary embolism and cerebral infarction, due to thrombosis, may also occur.

Pericarditis, through extension of the infarct to the epicardial surface, is reported as occurring in 15 to 80 percent of cases, by various investigators.

Mural thrombi, formerly found in about 50 percent of autopsied cases, and giving rise to embolic phenomena in about 25 percent of patients, are much less frequent. Such thrombi are usually found in the apex of the left ventricle. Pulmonary embolism, which is not uncommon following myocardial infarction, and is usually the result of thrombosis of systemic veins, is due to congestive failure. Cerebral thrombosis may also occur, probably due to failure.

Rupture of heart wall occurs in about 8 percent of cases, usually within 7 days after the development of the infarct. It has, however, occurred as early as one day and as late as 4 weeks. Death commonly follows rapidly. Two unusual types of rupture may be survived for longer periods of time. Rupture of the interventricular septum is rare, and the last such case we had was diagnosed clinically because of the development of a harsh systolic murmur and thrill. Rupture of papillary muscle, in posterior infarcts, is also rare, but also produces a loud murmur, but nearer the apex. Predisposing causes of rupture are hypertension or undue effort, and an unusual amount of haemor-

rhage and leucocytic infiltration in the area of infarction.

Aneurysm of the left ventricle is a not uncommon finding at autopsy, in about 8 percent of cases with myocardial infarction. It is thought to develop during the first 2 weeks. Rupture of these aneurysms long after the infarction, and when the wall consists of a thin layer of scar tissue is rare. They may, however, contain mural thrombus.

Schlesinger has indicated that one should keep patients who have had an infarction at rest, not only to allow the necrotic muscle to be replaced by scar, but also to allow the development of an adequate anastomotic circulation. One may carry this line of reasoning a stage farther and suggest that once a good scar has formed, gradual exercise should further stimulate the formation of anastomotic channels.

Acute Coronary Insufficiency

In my introduction I mentioned acute coronary insufficiency, which has been defined as "a deficient supply of oxygenated blood to the myocardium." The pathologic basis of this is coronary sclerosis and stenosis, either with or without occlusive lesions, by which I mean old or recent thrombi. In addition, cardiac hypertrophy in such cases is commonly found. The clinical manifestations of this syndrome may be sudden death, the sudden onset of angina pectoris, or the sudden onset of cardiac failure. With the latter two syndromes there may be myocardial infarction, but not with the first. The precipitating factors causing any of the three manifestations of acute coronary insufficiency may be shock, haemorrhage, or coronary thrombosis. All of these will result in myocardial ischaemia. It is also postulated by Oille²⁴ that a change in cardiac rhythm results in reduced cardiac output which in turn diminishes coronary blood flow, producing myocardial ischaemia. On the other hand, alterations in rhythm are certainly produced by myocardial ischaemia, which brings us back to the same place, that is, that acute coronary insufficiency means acute myocardial ischaemia.

To the pathologist, the syndrome of acute coronary insufficiency means sudden death, due to marked coronary sclerosis with or without recent thrombosis or intimal haemorrhage. Too often in such cases no recent thrombus or intimal haemorrhage is found, and there is no history of shock, haemorrhage, or anything else that might explain the acute myocardial ischaemia which presumably caused death.

In Yater's analysis of 336 cases of acute coronary insufficiency without gross myocardial in-

farction, there were 38 without complete occlusion of any artery, 148 with sclerotic occlusion and 117 with thrombotic occlusion. The cases with sclerosis alone, 184, or approximately 55 percent, did not have thrombotic occlusion of a coronary artery. An attempt was made by Yater to correlate the type of activity when the soldier was stricken, with the lesion found in the coronary arteries at autopsy, but there was no correlation. Because the pathological material in this series was collected from all over the world, and examination of arteries was not always complete, it is probable that a higher percentage of thrombi might have been found with more diligent search. The fact remains, however, that in acute coronary insufficiency, sclerosis alone, without thrombosis and without infarction, is often found, and we have no explanation for the mechanism of the sudden death. Yater postulates a "generalized vascular relaxation in the presence of a very labile vasomotor system, rather than the much talked of constriction of the coronary arteries." It is also probable that severe and unusual effort may result in an attack of acute coronary insufficiency in the presence of coronary sclerosis and stenosis. In Yater's series 12½ percent were engaged in strenuous effort when stricken.

Effort and Coronary Thrombosis

In analyzing the pathology of coronary thrombosis, I pointed out that intimal haemorrhage may initiate the formation of a thrombus, and that in fact, the haemorrhage alone may occlude the lumen. At the present time there is a wide discrepancy in the incidence of intimal haemorrhage as reported by Paterson and as reported by Wartman, Winternitz and others. Paterson has stated that the intimal haemorrhages are the precipitating cause of coronary thrombosis, and with this statement one cannot disagree in that it is quite obvious from studying the sections that these haemorrhages ruptured through the soft atheromatous plaque, destroying the continuity of the intima and therefore forming a locus for the development of a thrombus. The mechanism of the haemorrhage is, however, highly controversial as well as the incidence of such haemorrhages. Paterson states that any elevation of the blood pressure, such as caused by emotion or effort, may result in rupture of these capillaries because their walls are only supported by soft pultaceous material. A criticism of this statement might be made that pressure within the atheromatous plaque would also be increased whenever the pressure within the lumen of the artery is raised, and that pressure within the capillary would certainly not be any greater than pressure of the

surrounding semi-fluid material. This is a debatable statement, but another criticism can be offered in that Paterson was only able to demonstrate continuity of capillaries with the lumen in 4 cases, whereas in our series of 19 cases, we were only able to demonstrate continuity of capillaries with the lumen in 2. In the majority of the others, in which haemorrhages were found, we could trace continuity with vasa vasorum coming from the adventitia. Wartman also notes the greater number of capillaries derived from the adventitia rather than from the arterial lumen. One doubts whether elevation of pressure within capillaries derived from adventitia via arterioles, would be sufficient to cause their rupture. To generalize that elevation of blood pressure from emotion, stress or undue effort may precipitate coronary thrombosis, on such evidence, is unwarranted in my opinion. On the other hand, it is well established that low blood pressure plus anoxia, such as occurs in profound shock, will cause capillary rupture.

If thrombus is not precipitated by haemorrhage into the atheromatous plaque, one is left with the alternative explanation that the softened necrotic plaque ruptures into the lumen and the thrombus is quickly formed. It is difficult to conceive of any relationship between rupture of such a plaque and elevation of blood pressure.

Another approach to the question of effort and coronary thrombosis and acute coronary insufficiency is provided by the clinical analysis of Yater and associates, and Morris²³ and associates. In analyzing 866 cases of coronary artery disease in soldiers between the ages of 18 and 40 years, Yater found that the acute attack could only be correlated with strenuous activity in 27.6 percent, and in many of these a thrombus was found. More often the thrombus was old. He concluded that in some cases "the type of activity, particularly if strenuous, may have caused the additional demand for coronary blood flow that precipitated the fatal attack of coronary insufficiency." In other words, the activity did not cause the thrombosis, which was present before the activity began.

Morris, in an analysis of coronary artery disease in London transport and postal workers, found twice the incidence of coronary thrombosis and infarction in those in a sedentary occupation, as opposed to those engaged in a physically active occupation, such as bus conductor, or postman.

Conclusions

1. Coronary arteriosclerosis is a leading cause of death, of unknown etiology, but probably has an hereditary basis. Its development may be influenced by various endocrine disturbances, in-

flammation, and mechanical factors such as elevation of blood pressure. A contributing factor is abnormality of blood lipids, either in quantity or kind.

2. Thrombosis of coronary arteries usually occurs on a soft, necrotic atheroma, the mechanism being haemorrhage into the atheroma in at least 50 percent of cases from capillaries surrounding the soft lipid mass. These capillaries have their origin, in the majority of cases, in the adventitia, and less commonly are in direct continuity with the lumen of the artery. The cause of rupture of these capillaries is unknown. Another cause of thrombosis is spontaneous rupture of the atheroma.

3. Thrombosis does not always result in infarction. This depends on the adequacy of anastomotic circulation developed as coronary sclerosis progresses.

4. Myocardial infarction is associated in over 90 percent of cases, with thrombosis of a coronary artery.

5. Acute coronary insufficiency is a clinical syndrome, often resulting in sudden death, in which coronary thrombosis is found in more than half the cases. In the remainder, coronary sclerosis and frequently cardiac hypertrophy are found. The mechanism of death is obscure, but in some cases may be associated with anaemia or shock, but in many no precipitating cause of acute myocardial ischaemia can be found. A change in rhythm, causing reduced cardiac output, has also been postulated as a mechanism causing myocardial ischaemia.

6. The relationship of effort to the development of acute coronary insufficiency and coronary thrombosis is highly controversial. The evidence that intimal haemorrhage is due to effort is lacking. The clinical evidence supports the view that ordinary effort is not a factor, but that strenuous effort may be, in a small group of cases. My own opinion is that ordinary effort is certainly not a precipitating factor, but may in fact be a preventive measure, in that the heart is much like any other muscle in the body, and is healthier if exercised. Moderate exercise, in the presence of coronary sclerosis without symptoms, should stimulate the development of anastomotic circulation. One cannot deny, however, that violent and undue effort in the presence of marked coronary atherosclerosis, may precipitate acute coronary insufficiency.

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VOCATIONAL REHABILITATION----A SERVICE FOR THE DISABLED

DON W. RUSSELL

Director, Vocational Rehabilitation Service

The Problem of Disability

We have long recognized the problem of disability among our adult population and the need to restore these disabled persons to positions of self-respect and self-support. There can be no doubt that the establishment of the disabled in employment is a tremendous asset to the total economy of the State.

Of course, disability is a problem of the individual but its solution requires the utmost in co-operative effort by the citizens of each community. There are, in Arkansas, 20,000 adult disabled who could be returned to employment through receiving needed vocational rehabilitation services. There are 3,300 adults who become disabled each year who require assistance if they are to become employed. At the present time only about one-third of these persons are being served—the remainder are being supported by

friends, families or public and private assistance, with little or no hope of ever becoming employed. These persons need services leading toward self-support, not charity providing meat and bread alone. If these disabled who can become employed are to actually be employed, the cooperation of the local community, and the State is required. This is the basic philosophy behind the program of Vocational Rehabilitation—to assist the community and the disabled individual in solving the problem of disability.

What is Vocational Rehabilitation?

Stated simply, Vocational Rehabilitation is a service provided disabled adults for the purpose of assisting them to engage in suitable remunerative employment.

Who is Eligible?

All persons of working age may be eligible if they:

- (1) Have a physical or mental disability which results in functional limitations or limitations in activities which result in a substantial handicap to employment and,
- (2) May engage in remunerative employment after receiving vocational rehabilitation services.

Persons with minor disabilities are not served nor are persons with acute or transitory medical problems.

What Services May Be Provided?

Those services provided at no expense to the disabled person:

- (1) Medical examination to determine the existence of a disability, the extent of involvement and limitations thereby produced and whether the disability may be removed or reduced by treatment or surgery.
- (2) Counsel and Guidance to those who are eligible for and receive service.
- (3) Training for a job.
- (4) Placement and follow-up on a job.

Those services provided on the basis of the economic need of the disabled person:

- (1) Medical, surgical, psychiatric, or other treatment, including surgery, where the disability may be removed, stabilized or substantially reduced.
- (2) Hospitalization during treatment or surgery.
- (3) Prosthetic appliances.
- (4) Maintenance and transportation while receiving services.
- (5) Tools, equipment or licenses.

How Much Does the Client Pay?

One of the basic principles of Vocational Rehabilitation is that the disabled individual must participate to the maximum, financially and otherwise. The individual, therefore, is expected and required to pay to the extent that his financial condition will permit with Vocational Rehabilitation supplementing his resources as may be required. Vocational Rehabilitation is not a "hand-out" program for the parasites of society, but a "self-help" program for those who have desire, ambition and ability to work.

Physical Restoration in Vocational Rehabilitation

During the past ten years Vocational Rehabilitation has been operating a limited program of physical restoration for the disabled. This was inaugurated and has been continued because of the fact that the vocational possibilities of many disabled could be greatly expanded if the disability

could be stabilized, reduced or entirely removed. It is not the purpose or desire of Vocational Rehabilitation to operate a program of socialized medicine or complete medical care. The purpose of Vocational Rehabilitation is to render only those services needed by the disabled individual to restore him to employment and then permit the individual to pay his own way.

Vocational Rehabilitation recognizes the need for guidance in the physical restoration field. This guidance can come only from those professional persons who are working in this field—doctors, nurses, hospital administrators, etc. In order to operate in a sane and sound manner, Vocational Rehabilitation has developed the following:

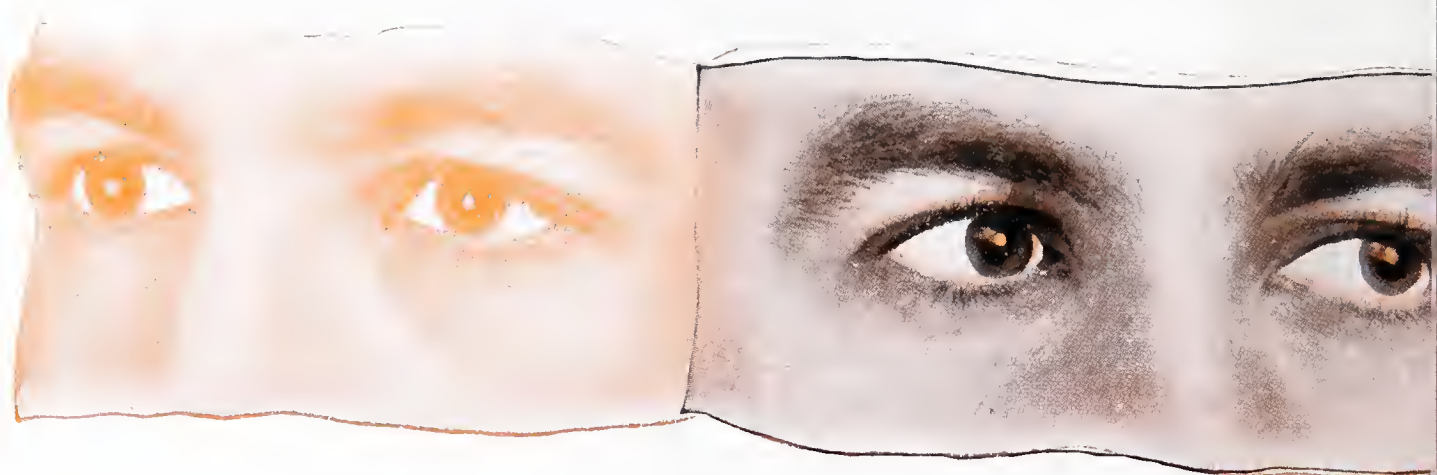
- (1) An Advisory Committee on Physical Restoration.

This is a 21-member committee appointed by the Director of Vocational Rehabilitation with the approval of the State Board for Vocational Education. These persons serve three-year staggered terms. The function is to recommend policies and procedures of program operation so as to insure sound practices. The following are the present members of the Advisory Committee:

Joe F. Shuffield, Little Rock
 Grady W. Reagan, Little Rock
 K. W. Cosgrove, Little Rock
 J. J. Monfort, Batesville
 Gilbert D. Jay, III, West Memphis
 Fount Richardson, Fayetteville
 R. B. Robins, Camden
 George C. Burton, El Dorado
 Robert Watson, Little Rock
 Louis A. Cohen, Little Rock
 Rev. John W. Kordsmeier, Little Rock
 Joe H. Hardin, Little Rock
 Frieda Wilhelm, Texarkana
 John Wm. Smith, Little Rock
 Frances C. Rothert, Little Rock
 Maurice J. Friedman, Little Rock
 Miss Linnie Beauchamp, Little Rock
 A. B. Dickey, Booneville
 R. C. Dickinson, Horatio
 W. R. Brooksher, Fort Smith
 L. H. McDaniel, Tyroneza

The Committee recently recommended the use of hospitals not approved by the Joint Committee on Accreditation upon application of the hospital and approval by the Advisory Committee. Another recommendation by the Advisory Committee is the use of medical doctors for treatment and surgery who are not members of specialty boards, subject to the request of the doctor and approval by the Advisory Committee. This should result in continued high standards of service with the service being

MORE AND MORE PHYSICIANS ARE TURNING



ACHRO

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More than a year of widespread use has established ACHROMYCIN as a true broad-spectrum antibiotic, well tolerated by both young and old. It has proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa. Compared to certain other antibiotics, ACHROMYCIN provides more rapid diffusion; it is also more soluble, and, once in solution, more stable.

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rendered closer to the homes of the disabled individual. The assistance of the Advisory Committee is essential to Vocational Rehabilitation in the operation of the physical restoration phase of the program.

(2) Medical Consultation.

Vocational Rehabilitation has a central office and nine local offices. A Chief Medical Consultant and eight local Medical Consultants are available on a part-time basis. These are as follows:

A. R. Sparks, Chief Consultant, Little Rock
G. Harrison Butler, Fayetteville
R. C. Shanlever, Jonesboro
E. Z. Hornsberger, Jr., Fort Smith
James R. Fall, West Memphis
C. Lewis Hyatt, Monticello
James B. Kittrell, Texarkana
G. Allen Robinson, Harrison
Chas. W. Reid, Pine Bluff

The Consultants advise and counsel with the Rehabilitation Counselors of each local office regarding the adequacy of the general medical examination, the need for special examinations and the over-all plan of physical restoration. No plan of physical restoration will be inaugurated by Vocational Rehabilitation without the approval of the Medical Consultant.

With this advisory and consultative assistance, Vocational Rehabilitation should experience no great difficulty in administering its limited, but necessary program of physical restoration to the medically disabled adults of the State.

In conclusion, the Director and the entire staff of Vocational Rehabilitation wish to express their sincere appreciation to the medical doctors of Arkansas who have contributed so generously of their time and energy in making the Arkansas Program of Vocational Rehabilitation one of the best in the entire Nation.

Obituary

OBIE R. KELLY, 69, died in his home in Sheridan, on April 21.

Dr. Kelly was graduated from the University of Louisville School of Medicine, Louisville, Ky., and began his practice at Carthage. He was president of the Grant County Medical Association, and a member of the Arkansas and the American Medical Associations. Recently he received a life membership in the Southern Medical Association.

He was also very active in education work. Be-

fore moving to Sheridan, he was a member of the Carthage School Board, and had been a member of the Sheridan School Board since 1916. He recently had been re-elected president of the Sheridan Board, beginning his 27th year in that capacity.

He was a life member of the Sheridan Parent-Teacher Association, and an honorary member of the Sheridan Rotary Club. He was a Baptist. A native of Grant County, he moved to Sheridan in 1913.

Survivors include his widow, Mrs. Ellen Forester Kelly; a daughter, and four grandchildren.

ELBERT CARROLL HUNT, 92, Conway, long-time Yell County physician, died May 1st at Memorial Hospital. He had been ill about two weeks.

Dr. Hunt retired in 1951 from the practice of medicine after 57 years, 25 of which were at Ola. He was mayor of Ola for eight years.

He graduated from Arkansas Industrial University, now the University of Arkansas School of Medicine, in 1892, and began practicing in 1894. Dr. Hunt's slogan during his medical practice was "all calls, regardless of weather or distance."

He was a life member of the Pope-Yell County Medical Society, and of the Arkansas Medical Association, a member of Petit Jean No. 298 Lodge, F & AM, Royal Arch Masons, Amritta Grotto at Fort Smith, Order of the Eastern Star and Ola Methodist Church.

He was born June 18, 1862, at Huntsville, and was married Dec. 8, 1902, to the former Cynthia Elizabeth Russell, who died in 1923.

Surviving are a son, twin daughters, two sisters, five grandchildren, and six great-grandchildren.

The funeral was conducted at Conway, and burial was at Liberty Cemetery at Greenwood.

C. L. HARRIS, 73, Melbourne, retired, died April 16 in his home.

His wife, Rosa Harris, two daughters, one son and four grandchildren survive him. Interment was in Melbourne.

CHARLES M. PLUNKETT, 84, pioneer Arkansas physician, died in Camden on April 12.

He had retired from active practice in Elliott several years ago. After graduating from the University of Arkansas School of Medicine in 1904 he returned to his native area and followed his profession for nearly 50 years.

He is survived by his widow, Mrs. Sallie Cook Plunkett, of Elliott; two brothers, and a number of nieces and nephews.

RECOMMENDATIONS OF THE POLIO ADVISORY COMMITTEE OF THE ARKANSAS MEDICAL SOCIETY CONCERNING THE POLIO VACCINE

EUGENE H. CRAWLEY

Chairman, Polio Advisory Committee

May 3, 1955

The polio vaccine has been released and made available without charge to first and second grade children throughout the nation.

There is only a limited supply of commercial vaccine available for administration by private physicians. For a time this supply will be far short of the anticipated demand. There is therefore need for guidance in the most effective use of this commercial vaccine that is available.

Therefore, the Polio Advisory Committee feel that the Medical Society recognize and follow the following resolutions.

- Whereas: (1) The first and second grade children in all public, private and parochial schools may receive vaccine supplied without charge by the National Foundation for Infantile Paralysis.
- (2) The commercial supply available to private physicians is insufficient for administration to all age groups.
- (3) There are certain age groups and individuals most likely to be benefited through receiving the vaccine, therefore:

Be it resolved:

- (1) While commercially available polio vaccine remains in limited supply, physicians are urged to reserve the vaccine for pre-first grade children over one year of age; for school children in grades three through eight and for pregnant women.
- (2) The public be informed of the temporary need for voluntary control.
- (3) The physician should not accept any, or give any, vaccine supplied by the patient regardless of label designated on the bottle or the story of the vaccine origin.
- (4) All used vaccine bottles and vials should be carefully destroyed when empty, by the physician to avoid any possible reuse.
- (5) The local community be alerted to the need for providing some method whereby vaccine can be made available for those in the priority groups, but are unable to pay.

FURTHER RECOMMENDATION OF THE POLIO ADVISORY COMMITTEE IN REGARD TO THE COMMERCIAL POLIO VACCINE

EUGENE H. CRAWLEY

Chairman, Polio Advisory Committee

Endorsed by

JOHN R. THOMPSON

State Referee for Polio Vaccine

The following considerations were kept in mind in making these recommendations:

- A. The medical society expects with confidence that the recognized producers of vaccine will distribute the polio vaccine in a fair equitable and impartial manner. Until conditions proving the contrary arise the normal channels of distribution will be preserved. In accord with President Eisenhower's recommendation, the program should be kept on a voluntary basis.
- B. Vaccination for polio is no different from other medical procedures of a similar nature. As in other cases of medical treatment the attending physician should have freedom of judgment in the limits of good medical practice.
- C. The delay in distribution of vaccine is temporary. Before the peak of the polio season adequate supplies of vaccine should be available for every child between 1-9 years, as well as the rest up to the age of 19 years, and pregnant women.

Therefore we recommend:

- (1) From the allocations set aside by the vaccine producers for a particular territory such amounts of vaccine should be released to individual physicians as are reasonable and equitable in consideration of the physician's type of practice. Particular considerations should be given to those serving the most susceptible groups.
- (2) The State Department of Health will make available figures on the representation of the most susceptible groups in the population by individual communities to be the basis for allocations.
- (3) In indigent cases each community must find means to supply vaccine free of cost. The local physicians will administer the vaccine without charge.
- (4) Should any problems, inequities, or abuse exist or arise, they will be referred for consideration and recommendation to the state referee appointed by the Governor.





MRS. MASON G. LAWSON, Little Rock
New President of the Woman's Auxiliary
to the American Medical Association.

"Our Mona" was installed at the June Atlantic City Meeting of the Auxiliary, and was fittingly honored for her many years of unselfish work, both in the Auxiliary, and for the public relations of the physicians of Arkansas, and of the United States.

She spent the month of May in appearances ranging from Wisconsin to Rhode Island to Mississippi, and to the west coast.

She was honored by the Arkansas Academy of General Practice in October, 1954, and expects to carry the gospel of the Woman's Auxiliary to the American Medical Association throughout the United States, and some of our neighboring countries during her coming year as president.

We salute Mrs. Lawson.

— ★ Editorial ★ —

WE LOST OUR TAW

Back in the days which were un-modern enough that we could stay on the school grounds after books, and have a few round of marbles, we had our problems. If a boy suddenly lost his skill, or his knack of shooting, or had a few days' slump, we'd say "he lost his taw." Or if he really lost his taw, or his best "shooting" marble, he fell down on his shots.

The phrase aptly describes the situation in which we of the A.M.A. find ourselves in regard to the Joint Committee of Hospital Accreditation which we acquired by the back door route when it became a financial burden of the American College of Surgeons.

The accreditation of physicians belongs to the A.M.A., not to the American Hospital Association. Nor is there much excuse in vesting too much of administrative authority in one professional group so that they have jurisdiction over an unrelated group which is without voice in its jurisdiction. The A.M.A. lost its taw when it alone failed to assume sole leadership in the accreditation committee. It should still be done. The Canadian Medical group would probably approve.

There is no reason to allow a hospital or any of its employees to pass on the professional qualifications of a practicing physician. The only group who can ultimately and satisfactorily do this is an organization of the physicians themselves.

The pioneering of the American College of Surgeons in elevating the standards of hospitals is dutifully acknowledged, and the right of the American Hospital to have a hand in its own surveillance is unquestioned. The fact remains that the Joint Committee has from three to five parents, one of them of an entirely unrelated genus, and, it's a wonderful progeny that can satisfy such an inheritance. The problem really needs solution and the way is clear.

"When the National Foundation for Infantile Paralysis announced that the vaccine works and is 80 to 90 per cent effective in preventing paralytic polio, the biggest medical news story of the cen-

tury unfolded amid the fanfare and drama typical of a Hollywood premiere. More than 300 press, radio, and television people were on hand to cover the event. Within an hour after the historic announcement, A.M.A. Press Director, etc."

The above quotation is a splendid example of the way NOT to put scientific facts before the public. Medical science, first, is not exact, is hard to understand, and almost never 100 per cent accurate. Medical discoveries should be announced as soon as possible by their creators, giving both positive and negative findings. Similarity to the phonies of Hollywood should be meticulously avoided. Dr. Able provided adrenalin without such histrionics, Banting and Best supplied insulin. If the National Foundation for Infantile Paralysis used this theatrical approach for the filling of their own coffers, they have reached a new height in bad manners.

IKE SPANKS HOBBY FOR GRABBING AT POLIO VACCINE

We can visualize times when spanking Mrs. Hobby might be a pleasant pastime, but we can think of no occasion where she more deservedly was reprimanded.

RURAL HEALTH CONFERENCE

June 28 - 29

Chairman Ben Saltzman of the Rural Health Committee announced the annual conference for Little Rock June 28-29, and expects this Fifth Arkansas Rural Health Meeting to be the largest yet held. More than 600 people from 20 organizations are expected to attend.

W. H. Pruitt, Camden, will organize groups to carry out local rural health projects, and James Wortham, Little Rock, will conduct a panel on the practical aspects of nutrition.

This conference is one of the most popular of the affairs sponsored jointly by the Arkansas Medical Society, and civic groups on the state.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

RENAL TUBERCULOSIS

By JOHN K. LATTIMER, M.D.

Transactions, National Tuberculosis Association, May, 1954

Destructive tuberculosis of the kidneys occurs in about four per cent of patients with pulmonary tuberculosis. As yet, there has been no decline in the incidence of this blood-borne complication as a result of the advent of streptomycin and other drugs.

Undetected renal tuberculosis can be very serious as it tends to be bilateral. The early diagnosis of renal involvement is difficult since it is usually asymptomatic for months or years after its onset. Urinary burning and frequency usually appear later when successful treatment is difficult. All patients with pulmonary tuberculosis should have periodic urine examinations for pyuria for five to ten years after their pulmonary infection. In early involvement of the kidneys, the number of pus cells may be as small as one to three per high power field in specimens of specific gravity 1.015.

The rate of progression of a destructive kidney lesion is highly unpredictable. Some lesions can destroy the kidneys completely within four years, while others may take ten or more years to accomplish this. Rarely the lesions may heal spontaneously. Every renal lesion must be regarded as a dangerous complication. Since both kidneys are usually infected by tubercle bacilli in any hemic dissemination, both may become the site of caseo-cavernous tuberculosis. Usually, however, one kidney breaks down first. In approximately 50 per cent of patients, the other kidney will break down if untreated.

Renal tuberculosis is always secondary to some other focus in the body. In the United States this focus is usually in the lungs. When a hemic dissemination occurs the glomeruli are infected first, then the region of the narrow loop of Henle. This medullary lesion grows larger to become necrotic and slough out, leaving a small papillary abscess cavity which can empty on the tip of the papilla or in the fornix on either side of the papilla. This is the first lesion of renal tuberculosis which is detectable by X-ray. As the cavity grows it may destroy the entire contents of the renal pyramid

served by that papilla. The cavity may then extend out to the very capsule of the kidney, which tends to sink in upon the scarred and destroyed calyx. If the abscess does not slough out, it may be seen as a bulging yellow mass of caseous material under the capsule. As the tubercle bacilli and infected caseous material drain into the lumen of the kidney pelvis, other calyces are infected directly. The simultaneous infection of several pyramids often occurs.

Stricture formation as a result of infected material escaping into the kidney, pelvis, ureter, and bladder may choke off the neck of a single calyx, the neck of a major calyx serving half the kidney, or may cause a stricture of the ureter which will kill the entire kidney with great rapidity. Disastrous bladder contractures may eventually follow. The time interval between the primary pulmonary infection and the detection of kidney tuberculosis in one large series averaged eight years. The reason for this long delay is the fact that, even though destruction may be occurring and bacilli going down the ureter, no urinary symptoms are caused for months or years.

Bladder symptoms will eventually occur, however, after a long enough period of time. Hematuria will also eventually occur in most patients if the infection is permitted to persist. Occasionally, hematuria is the presenting symptom. Dull pain over the kidney is frequent, but fever or elevation of the erythrocyte sedimentation rate is rare with renal tuberculosis. Pyuria, together with no pyogenic bacteria on routine culture, should lead to a suspicion of tuberculosis.

The advent of chemotherapy has been a great blessing for patients with kidney tuberculosis. In 1946, even streptomycin alone, produced a dramatic improvement of symptoms in patients whose bladders were not already contracted. The decline in the numbers of deaths from uremia has been impressive. Combined therapy with PAS and streptomycin, given concurrently for a period of one year, has given considerably better prelimi-

nary results than did streptomycin alone. It did not appear to matter whether the streptomycin was given daily or twice weekly.

Isoniazid alone, like streptomycin, does not convert large caseous renal lesions readily and often drug resistance appears after several weeks of treatment. Isoniazid has a distinct danger for patients who are uremic. It is a central nervous system stimulant; and among other disadvantages can cause convulsions if the blood level rises too high. Blood levels should be done on all patients who show any elevation of urea nitrogen or whose kidney function is diminished.

Prostatic lesions which have resulted from, and coexist with, renal lesions, or which remain after a tuberculous kidney has been removed, are currently treated with a combined regimen of streptomycin, PAS, and isoniazid for a period of at least one year. Radical prostatovesiculectomy is advised only in the rare cases with intractable pain. A tuberculous epididymis is removed only after three weeks of chemotherapy if the patient is sterile.

Unilateral, destructive tuberculosis of the kidney is probably best treated by nephrectomy followed by one year of combined treatment with streptomycin and PAS. To date, the presence of any lesion large enough to be visible by X-ray has heralded a poor prognosis for permanent conversion by chemotherapy alone. The newer chemotherapeutic regimens may justify a trial of at least one year of chemotherapy before surgery is advised. The operation should be postponed long enough to make certain that the urine from the

contralateral kidney is free of tubercle bacilli and pus cells. In selected cases partial resection of the involved kidney area may be advisable, after four to six months of combined therapy with streptomycin and PAS. The period of treatment should be at least one year.

Bilateral, inoperable renal tuberculosis is now treated with combined chemotherapy for at least one year. If pyuria still persists a second year of treatment may be given. Patients are kept in a semi-ambulatory rest regimen for the first six to twelve months. At the present time regimens employing isoniazid, streptomycin, and PAS together for a period of one year are being tested. Some patients will also be tested on a combination of isoniazid and another tuberculostatic drug for a second year. If one kidney is only slightly worse than the other, the worse kidney should not be removed. The patient will only die sooner.

Prostatic and epididymal tuberculosis are now being treated with one year of combined chemotherapy. Epididymectomy is advised for lesions which are obviously very large, caseous, or necrotic. The operation is followed with one year of combined chemotherapy.

Eight years of observation of bacteriological data, roentgenographic data and symptomatic and survival data have convinced us that modern chemotherapy is certainly effective in modifying the formerly lethal course of renal tuberculosis. A careful search for small numbers of pus cells in the urines of all patients with a history of pulmonary tuberculosis is the most valuable test which can be done, for it may lead to the early detection and successful treatment of this disease.

Proceedings of Societies

The First Councilor District Medical Society held its 105th Semi-Annual Meeting on Thursday, May 12th, at Paragould.

Robert Paine of St. Louis talked on "Advances in Treatment of Heart Diseases"; James S. Coston of St. Louis discussed the "Influence of Antibiotics on Diagnosis in Otolaryngology," and "The Diagnosis and Management of Some of the Common Skin Diseases Seen in General Practice" was the subject of Vonnie A. Hall of Memphis. Richard V. Ebert of Little Rock read a paper on "The Clinical Significance of Dyspepsia."

A tea for the ladies was given by the Greene-Clay County Auxiliary.

The First District will send J. H. McCurry to the A.M.A. Convention in Atlantic City. The meeting voted support of the Brooksher Scholarship Fund and recommended that John Wm. Smith of Little Rock be authorized to invest the present fund in accordance with his judgment.

The Association of Tumor Clinic Staff Members in Arkansas were guests of the Bowie-Miller County Medical Society April 28 in Texarkana. W. H. Handley, Jr., El Dorado, is chairman, and Frank Kumpuris, Little Rock, is vice-chairman. The program included J. W. Burnett, Texarkana, president

of the Miller County Medical Society, William B. Harrell, Texarkana, Director of the Host Clinic.

Visiting Physician Dudley M. Jackson, San Antonio, gave a film on "Breast Examination," and Morton L. Levin, New York, talked on "Lung Cancer and its relationship to Cigarette Smoking."

The South Central Region of the College of American Pathologists and the Arkansas Society of Pathologists met in Little Rock on May 7th. About 50 physicians attended from eight states. The all-day meeting was held at St. Vincent's Infirmary.

Those in attendance were the guests of M. J. Kilbury, Sr., at cocktails and dinner at the Little Rock Country Club.

New officers elected were: President, E. Lloyd Wilbur, Little Rock; Vice President, Carroll F. Shukers, Little Rock; and Secretary, A. S. Koenig, Fort Smith.

The Third Councilor District Medical Society met April 28 at Forrest City. Out-of-state visitors were Fontaine Moore, and Richard L. De Saussure of Memphis. Eugene Crawley and Robert Knight of Little Rock were on the program.

Ouachita County

The Ouachita County Medical Society met in regular monthly dinner session Thursday night, May 5, 1955, at Camden. Sam B. Thompson of Little Rock spoke on the subject of "Backache."

R. B. Robins, Secretary.

Personal and News Items

A. J. Brizzolara, Little Rock, is the author of "Magnet Extraction of Bobby Pins from the Gastro-Intestinal Tract" in the February number of the Archives of Otolaryngology.

Katherine Dodd, Little Rock, addressed the Tennessee State Pediatric Society on "Meningitis" at their annual meeting April 11-12 in Chattanooga.

Earl Parsons, Little Rock, has been appointed a member of the Committee of Regional Organizations of the American Group Psychotherapy Association.

R. C. Dickinson, Horatio, was an honored guest at Pre-Med Day May 14 at the University of Arkansas at Fayetteville.

Richard V. Ebert, Little Rock, addressed the First Councilor District Medical Society in Paragould on May 12.

James M. Kolb, Clarksville, was master of ceremonies at the annual Johnson County Medical Society Banquet where nearly 100 physicians were in attendance on May 4.

Van Buren Public Library has for sale a new edition of Schaeffer's "Pathology in General Surgery," University of Chicago Press. Write direct if you're interested.

Alfred Kahn, Jr., has moved into his new office building at 1300 West Sixth Street (at Pulaski) in Little Rock.

R. B. Robins, Camden, addressed the Nebraska Medical Society on May 19 in Omaha, and the South Dakota Medical Association at Mitchell, on May 24.

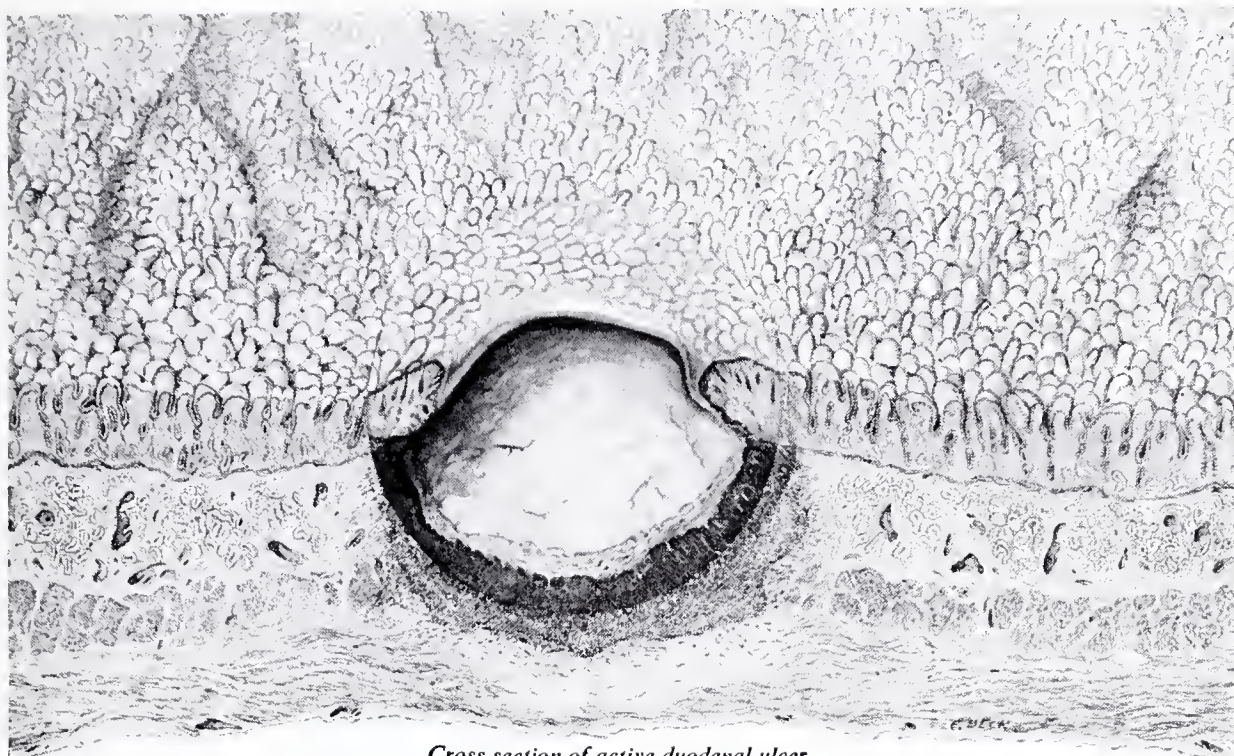
BOOK REVIEWS

Pomp and Pestilence: Ronold Hare, Professor of Bacteriology, University of London at St. Thomas's Hospital Medical School. Pp. 224. The Philosophical Library, Inc., New York. 1955. \$5.75.

A popular historical account of our parasites, pests, and pestilence as they have affected humanity, is presented. No reason is apparent for the use of the word "Pomp" in the title, except for its euphony, but the whimsical style of the writer presents a volume that gives an entertaining story of our microscopic friends and enemies.

The reader is led through the effects of parasites, and bacteria on our human development through the past 2,000 years. The details are philosophical, rather than scientific, and the book can be picked up with interest and entertainment for a few minutes random reading, or it can be enjoyed and read in one sitting of a few hours. A final chapter on "Notes and References" includes much reference to historical literature and numerous anecdotes supplementing the text.

Christopher's Minor Surgery—Seventh Edition—Edited by Alton Ochsner, M.D., Micheal E. DeBakey, M.D., Professor of Surgery, Baylor University College of Medicine, and William Henderson, Professor of Surgery, Tulane University of Louisiana School of Medicine. Pp. 547. Illustrated. W. B. Saunders Company, Philadelphia. \$9.00. 1955.



Cross section of active duodenal ulcer.

Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthine.

"In studying¹ the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

"... our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility. . . .

"Prompt relief of ulcer pain by ganglionic blocking agents . . . coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthine Bromide (β -diisopropylamino-ethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy² Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors² is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.

The Seventh Edition of Christopher's Minor Surgery, edited by Ochsner and DeBakey, bears little or no similarity to the previous editions of this classic, except in the general subject-matter treated. In the words of the editors it is "virtually a new book" in that it represents the combined efforts of 21 authors writing in their respective fields of surgical specialties, numbers about 400 pages less than former editions, and has a completely new set of illustrations. This volume has brought up to date many concepts and measures applicable to the practice of minor surgery, and because of its relative compactness, an exceedingly handy and valuable reference book for the doctor in his office, and the student in his surgical clinics.

Of particular interest are the introductory chapters on instruments and supplies, anesthesia and resuscitation, and some practical considerations on the role of the surgical resident. It has been the intention of the editors to integrate the various disorders according to systems, which indeed greatly facilitates the reader's use of the book.

"Management of Addictions"—Edited by Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Pp. 413. Philosophical Library, New York. Price \$12.00.

This volume is largely a compilation of articles by different authors, which have appeared recently in a number of medical, psychiatric, and legal journals. Since it is a compilation, and not the work of a single author, it has the virtue of approaching the problems of alcoholism and drug addictions from a variety of vantage points, but, by the same token, suffers from the repetition of basic concepts as each author develops his theme.

Several of the authors make reference to the value of the treatment obtained by following the program of Alcoholics Anonymous, and one author presents his experience with hypnosis. The principles of psychotherapy are outlined as well.

The editor has devoted less space to the drug addictions than to alcoholism. Nevertheless, there are a number of good articles on the habitual use of barbiturates, demerol, dilauded, codeine, and heroin.

This book should prove of value to psychiatrists, sociologists, and those who are confronted with the management of addictions to alcohol, and the drugs discussed.

—J. Hervey Ross.

Fluoroscopy in Diagnostic Roentgenology. Otto Deutschberger, M.D., Assistant Clinical Professor Radiology, New York Medical College. W. B. Saunders Company, Philadelphia. 771 pages. Illustrated. 1st Edition. 1955. \$22.00.

This is a comprehensive volume which residents in radiology would find of value although the sections on chest and gastroenterology should be of interest to the internist and general practitioner. Description of fluoroscopic equipment and fundamentals of fluoroscopic protection are given adequate coverage. Much of the subject-matter includes regions of the body which in actual practice are better studied by radiographs, with fluoroscopy in most instances being an adjunct.

Details of fluoroscopic technique are given in full, and interpretation of fluoroscopic findings are complete which would assist both a beginner in the field, and serve as a valuable and complete reference for a more practiced roentgenologist.

The book is supplied with an excellent index, and there is a wealth of references with each chapter.

Eight hundred eighty-eight illustrations, consisting of X-ray "positives" to simulate the fluoroscopic image, are

utilized, giving a broad coverage to normal and pathologic roentgenology.—H. W. Ward.

Current Therapy 1955—Edited by Howard F. Conn, M.D. Pp. 692. W. B. Saunders Company, Philadelphia. Price \$11.00.

This year's edition of **Current Therapy** amply lives up to its claim of offering the practicing physician the latest approved methods of treatment for practically the entire gamut of human ailments. Having almost 300 contributors, it brings the consultant therapeutic suggestions arising from a wide and varied clinical experience. It is obvious that a volume which appears annually can have few changes from year to year. However, it does offer information on the possible toxic effects of the latest drugs as they have been observed during the preceding months, without, at the same time, overlooking the tried and true remedies of the past. This is a must for every physician.

—J. Hervey Ross.

Clinical Diagnosis: Elmer G. Wakefield, M.D., F.A.C.P. Diplomate, American Board of Internal Medicine; Consulting Physician, Section of Medicine, Mayo Clinic; Associate Professor of Medicine, Mayo Foundation for Medical Education and Research, University of Minnesota. Appleton-Century-Crofts, New York. 1st Edition. Pp. 1,611. Illustrated. 1955. \$.....

In recent years it has become fashionable for an author to get a number of his friends and corroborators to "gather" a book from many sources, instead of sitting down to the laborious task of writing the book himself. This method will have its proponents, and its opponents. Some will pull the worn-out and fallacious remark that no one man can keep abreast of advances in medicine. Since it is questionable that medical progress is of the rate indicated, a treatise by a single author is welcomed, and is almost unusual.

Dr. Wakefield's teaching experience, and his position of directorship in a large clinic has evolved for his book a clear approach to the problem of clinical diagnosis. The three parts are divisions of a clinical grouping, not an anatomical one. He follows these divisions meticulously. His approach to the patient who presents a problem in diagnosis is direct. The sick man is an individual, not a mass of walking anatomical material. Discussion of the diagnostic points of an entity is complete, but the author is careful to limit himself to the complete diagnosis, not the differential diagnosis. The positive and negative findings are reported in detail. The sentences are, as a rule, short, and specific. There is an extensive and unusually complete index, facilitating the use of the book. This is a complete text for a mature medical thinker. It will live for a generation as an outstanding work in clinical diagnosis.





L. H. McDANIEL, M.D.
TYRONZA
President
Arkansas Medical Society
1955-1956

The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

JULY, 1955

No. 2

79th Annual Session **Arkansas Medical Society**

PRESIDENT'S ADDRESS*

FIRST GENERAL SESSION

W. R. BROOKSHER, M.D., Fort Smith

The continued growth and progress of an organization is directly proportional to the interest, energy and enthusiasm which its membership, individually and collectively, manifests in the organization. Fortunately, the persistent activities of government, quasi-government and "dogooder" agencies, to alter, modify and to establish a radical departure in the accepted plan of medical care of the American people have but served to unite in a more cohesive association those individuals and organizations within the medical profession as they might not otherwise have attained. The necessity of adopting and maintaining alert and aggressive opposition to the myriad plans which the would-be reformers have urged has brought to the medical profession an unanimity of attitude and organizational cooperation not previously considered possible.

The Arkansas Medical Society has participated without stint in these group efforts. In fact, we have had on more than one occasion, the gratifying experience of initiating steps which, with the help of other state societies, have forestalled some of the proposed schemes.

During the past year our Society has maintained its vigilant and earnest concern with the increasing flow of newer ideas for revolutionizing medical practice. In this connection, it is most encouraging to observe the spread of individual participation by our members in the affairs of the Society.

The major functions of this Society are conducted by its Council and Committees. The past

year has been one of additional responsibilities for our Council and Committees. These duties have been discharged with credit to all.

Our Committee on Medical Legislation functioned in the recent state legislative session most commendably, enjoying the full confidence of the legislative bodies. Noteworthy among their accomplishments was the passage of a much-needed revision of the medical practice act.

The Committee on Rural Health again held the Rural Health Conference, which has each year demonstrated its contribution to a better understanding of rural health problems and cooperatively seeks their solutions.

The Committee on Medical Education has studiously analyzed the extension of the program of the University of Arkansas School of Medicine and its relationship to the private practice of medicine and to the public, making recommendations, after mature deliberation, which have, in part, been adopted by the Board of Trustees and the School.

The Committee on Industrial Health conducted the first annual Conference on Industrial Health, a well-attended and profitable meeting.

The Committee on Public Relations is pursuing a carefully-planned program and this year sponsored the formation of a Medical Assistant's Society, whose first annual session was held in this hotel yesterday.

The scientific program which you are about to hear represents the diligent performance of the Committee on Scientific Work.

* Read before the Seventy-ninth Annual Session, Arkansas Medical Society, Hot Springs National Park, May 30th, 1955.

The Advisory Committee on Tuberculosis successfully sought legislative action to further tuberculosis control in Arkansas.

A special session of the House of Delegates held last year served to acquaint and secure the wider support of the membership in proposed legislative changes.

Most commendable has been the work of the Advisory Committee on Poliomyelitis which appears to alone have understood the problems which would arise with release of the Salk vaccine. Here the Arkansas Medical Society again pioneered in the realization of the basic concepts of the impact of new ideas and methods upon the relationship between doctors and patients. Today, after all the vacillation which has attended the release of the vaccine, their recommendations stand as a sane, orderly method for its distribution. The situation which has developed over the production and distribution of this vaccine is perhaps the most confused, thwarting and purposeless to ever occur as the result of interference by the Federal government in the affairs and lives of a free people. The Salk vaccine was developed by physicians with the aid and assistance of a voluntary health agency. At no point did the Federal government enter into this discovery. Other dread diseases have been eradicated by vaccines similarly developed by physi-

cians and distributed by reputable pharmaceutical manufacturers with no need for controls other than those now imposed by law, public opinion and competition. At no time were these subjected to the restrictions which are now being imposed upon the manufacture and distribution of the poliomyelitis vaccine. The final result, the practically complete disappearance of smallpox, diphtheria, typhoid fever, and other diseases, resulted without the calling of innumerable conferences in Washington, without the release today and the banning tomorrow, without columns of newspaper interviews, without a flood of bills in Congress, and certainly with none of the agitation and turmoil so present with this latest discovery. Perhaps the expressed opinion of a Cabinet officer, testifying before a Congressional Committee: "No one could possibly have foreseen the demand which would come with the announcement that this vaccine had been developed," truly typifies the disordered thinking of a control-minded government. To term this a naive statement is sheer flattery.

The result is that today orderly, planned distribution of a vaccine to prevent poliomyelitis has been alarmingly interrupted, parents are mystified and uncertain, a shortage of supply has developed and no revealing announcement has yet been made by those who have imposed the



Outgoing President W. R. Brooksher administering oath of office to in-coming President L. H. McDaniel, final general session June 1st, 1955, Ballroom, Hotel Arlington, Hot Springs.

restrictions of possible errors in manufacture, of inspection oversights or other reasons which might have warranted these unusual restrictions.

This is but another instance which serves to show that we have failed to halt the oppression of the Federal government over our personal and professional freedom. We seem to be more and more willing to let Washington assume more and more of our local responsibilities. The very fact that scattered calls have arisen for governmental controls over production and distribution of this vaccine is a reflection of the lack of confidence we have in ourselves and of our disinclination to assume our rights for citizen control.

Continued acceptance of this lethargic way of citizenship will mean further and further extension of controls and will bring an end to the

American way of life as we have known it. Whether this is to happen or not is your responsibility and mine.

It has been my pleasure to know most of you; it has been my good fortune to number many of you as my friends. I am firmly convinced that each of you is dedicated to the service of humanity, that you are honest and God-fearing, that you seek only to relieve, cure and comfort the sick; that, permitted to continue as a physician and a citizen without regimentation, restriction and interference, you will bring, as always, the best possible medical care and the force of an enlightened, earnest citizenship to these United States. It shall always be my privilege to go along with you.



President's Inaugural Address

L. H. McDANIEL, Tyronza *

This day is the greatest day of my life and this moment is my greatest moment. A man's birth, marriage, and death are epochs in the history of his existence. The time of his greatest recognition is therefore his greatest moment. For this moment I give you not only my thanks but my pledge of giving the Arkansas Medical Society, our Medical School, and the citizenry of Arkansas my best efforts in helping to make this next year one of progress, achievement, and satisfaction.

I would be ignorant or dishonest were I to tell you that we have no problems, for everyday new problems confront us—problems that will demand our best efforts in their solution.

Our Medical School, our State Hospital, our State Board of Health, our great Medical Center, each looks to the Arkansas Medical Society for counsel, for leadership and for constant loyalty and enthusiasm to help them put over a program; yes, to help them do a good job even better.

The willingness of busy physicians to serve on the committees for the coming year is an inspiration. To make our organization even more democratic we are putting on our committees new blood, new ideas, and new enthusiasm—except in special instances where that committee has not completed their assigned projects. To the members of the various committees whose terms have

expired we ask your continued support and counsel to the new members on said committees for it has been truthfully said that a Medical Society consists of a group of loyal members, cemented together by various committees plus a few officers to correlate and present the decisions of the committees. I am thankful that our Arkansas Medical Society is such an organization.

May we each one put our shoulder to the wheel—attack the problems that confront us in the coming year with zeal and vigor, ever-remembering that the welfare of the individual patient transcends every other phase that may enter into every physician—patient relationship, and that our fellow physician is always our brother and never our competitor and may the coming year bring unforeseen blessings not only to our nation but also to our beloved Wonder State. May we be living examples of the thought as follows:

He has not served
who gathers gold,
Nor has he served
whose life is told
Of deeds of triumph
he has done
But he has served
who now and then
Is found helping
his fellowmen.

* Read before the Seventy-ninth Annual Session, Arkansas Medical Society, Hot Springs, June 1, 1955.

PROCEEDINGS

SEVENTY-NINTH ANNUAL SESSION

ARKANSAS MEDICAL SOCIETY

Arlington Hotel, Hot Springs

May 30th, 31st, and June 1st, 1955

FIRST GENERAL SESSION

Monday, May 30th

Ballroom

The meeting was called to order promptly at 9:00 A.M. by President Brooksher.

The invocation was given by Reverend E. D. Galloway, First Methodist Church, Hot Springs.

President Brooksher addressed the Society as reported on page 21.

The Scientific Session, presided over by J. J. Monfort, proceeded as follows:

Burrill B. Crohn, New York, "Regional Ileitis."

Stewart Wolf, Oklahoma City, "Headache Mechanisms."

Fred J. Hodges, Ann Arbor, Michigan, "X-Ray Signs of Small Bowel Dysfunction."

Joseph H. Pratt, Rochester, Minnesota, "Gynecological Surgery in the Geriatric Patient."

James H. Ferguson, New Orleans, "The General Practitioner and the Sterility Problem."

Monday Afternoon, May 30th

SECTION ON INTERNAL MEDICINE

The section of Internal Medicine held a luncheon in the Fountain Room with Albert Hammon presiding. Following the luncheon, a symposium was held with Burrill B. Crohn, Stewart Wolf, O. T. Bailey, and Fred Hodges participating. William L. Davis presided.

ARKANSAS ACADEMY OF GENERAL PRACTICE

The Arkansas Academy of General Practice held its breakfast and Spring business meetings at Phillips Drive In, where a luncheon was also held. Alfred Kahn furnished the scientific program with a paper, "Hiatus Hernia."

OBSTETRICS AND GYNECOLOGY

The Section on Obstetrics and Gynecology held a luncheon in the Banquet Room. Calvin Simmons presided. Following was a symposium participated in by Joseph H. Pratt, James Fergu-

son, William B. Harrell, Frances Rothert, and Robert Sherman, with J. F. Kelsey as Chairman.

FIRST SESSION

HOUSE OF DELEGATES

Monday, May 30th, 1955

Speaker T. Duel Brown called the meeting to order at 4:00 P.M.

Secretary Monfort called the Roll of Delegates.

The Chairman of the Credentials Committee, Harry Murry, reported the credentials of the delegates present had been examined, found correct, and that a quorum was present. The following delegates, by counties, were present:

BAXTER, Ben N. Saltzman; BENTON, Kenneth A. Siler; BOONE, D. L. Owens; BRADLEY, George Wynne; CARROLL, James S. Priddy; CHICOT, H. W. Thomas; CRAIGHEAD-POINSETT, M. O. Peeler, J. H. McCurry; CRITTENDEN, Milton Deneke; CROSS-ST. FRANCIS, Austin F. Barr; DESHA, H. T. Smith; DREW, J. P. Price; FRANKLIN, C. C. Long; GARLAND, Lee-man King, Thomas Durham; GREENE-CLAY, A. H. Maddox; HEMPSTEAD, Jim G. Martindale; HOWARD-PIKE, Uthel L. Smith; JOHNSON, Robert H. Manley; LAFAYETTE, R. H. Harrison; LAWRENCE, J. B. Elders; MISSISSIPPI, Eldon Fairley; MONROE, Ed D. McKnight; NEVADA, J. B. Hesterly; OUACHITA, Henry Hearnberger; PHILLIPS, Reuben L. Chrestman; POLK, L. K. Williams; PULASKI, Robert D. Jones, J. W. Headstream, Daniel H. Autry, Alfred Kahn, Jr., Edgar J. Easley, G. W. S. Ish, William S. Orr, Edwin F. Gray; RANDOLPH, W. E. Hamil; SEBASTIAN, Art B. Martin, L. A. Whittaker; SEVIER, Charles N. Jones; UNION, J. B. Wharton, Jr., Warren S. Riley; WASHINGTON, Coy C. Kaylor.

Upon motion by Kolb and Murry, the House voted to seat the following members as delegates in the absence of regularly elected delegates:

GARLAND, Richard F. Graham; INDEPENDENCE, O. J. T. Johnston; JEFFERSON, H. J.

Morris; LEE, Floyd S. Dozier; MILLER, Harry E. Murry; POPE-YELL, Roy I. Millard; PULASKI, Charles R. Henry, John T. Herron; SEBASTIAN, S. Wright Hawkins; WHITE, Sam J. Allbright.

Speaker Brown then introduced Mrs. George Turner, El Paso, Texas, President of the Woman's Auxiliary to the American Medical Association, who addressed the House:

"It is indeed a pleasure to me to be here for the annual meeting of the Arkansas Medical Society and to bring you greetings from the Woman's Auxiliary to the American Medical Association. This is my last official visit to a state convention. You may not know that this organization is now 33 years old, having been organized by Mrs. S. C. Red of Houston, Texas. We have about 1,500 county auxiliaries and a membership of 70,000.

"Our first objective is to promote friendliness among doctors' families. We feel we have done this and have now accepted a program of work to help advance medicine. We know there are many things with which doctors are faced other than caring for the sick, and it is in this field that we believe the Auxiliary can assist by offering sensible evaluations, sound thinking on medical current events and opinions, as we encounter them.

"A doctor's wife is a lay person, and yet she is intimately associated with the medical profession, and we feel that she can be very valuable in assisting in the interpretation of medicine and its program in her community.

"Our program is two-fold: it is self-education in our auxiliary meetings, and service and community health in the communities in which we live. Our program closely

parallels yours. We help on the American Medical Education Foundation, legislation, mental health, civil defense, nurse recruitment, and Today's Health.

"Arkansas is pretty well organized. I find by looking at last year's report that you have: 57 county medical societies, with 26 auxiliaries; and 973 A.M.A. members with 734 auxiliary members. The auxiliary membership does not quite parallel the membership of the Arkansas Medical Society. The Auxiliary would appreciate it very much if your wife is not a member of the Auxiliary, if you will encourage her to become one of our members. We need the helping hands of all eligible members, and we need the financial support of their dues.

"The theme of our work this year has been 'Leadership in Community Health.' We feel that this is a fitting theme for women who are married to the medical profession and dedicated to the community health through a program of health. Our aim is to develop its objectives and the program of the Auxiliary so that we will have your approval and the approval of the people in the communities which we serve."

The Speaker then introduced Mrs. Louis K. Hundley, President, Woman's Auxiliary to the Southern Medical Association, Mrs. Mason G. Lawson, President-Elect of Woman's Auxiliary to the American Medical Association, and Mrs. Hoyt Choate, President, Woman's Auxiliary to the Arkansas Medical Society.

The following fraternal delegates were introduced by the speaker and brought greetings from their respective associations: H. D. Padgett,



President W. Brooksher presenting silver trays, on behalf of the Arkansas Medical Society, to Mrs. Mason Lawson, President Woman's Auxiliary to American Medical Association, and Mrs. Louis Hundley, President Woman's Auxiliary to Southern Medical Association. Annual Banquet, Arlington Hotel, Hot Springs, May 31st, 1955.

Texas; E. M. Woodson, Oklahoma, and R. L. Sanders, Southern Medical Association.

Upon motion (Whittaker, Gray) the House adopted as correct the minutes of the 78th Annual Session as published in the June, 1954, issue of the Journal of the Arkansas Medical Society.

Committees of the Society whose reports had appeared in the March, 1955, issue of the Journal of the Arkansas Medical Society, were asked to read any supplement to their report which they might have. Published committee reports were referred to either Reference Committee Number 1 (C. C. Long, Ozark, Chairman; L. A. Whittaker, Fort Smith; M. J. Kilbury, Jr., Little Rock) or to Reference Committee Number 2 (H. W. Thomas, Dermott, Chairman; Jack Kennedy, Arkadelphia; Swan B. Moss, McGehee).

Reports not previously printed in the Journal were read as follows:

REPORT OF THE COUNCIL

LOUIS K. HUNDLEY, Chairman

During the year 1954-55, the Council conducted business for the Arkansas Medical Society as follows:

1. Adopted a resolution expressing appreciation for the work done by Dave Peel as Chairman of the Workmen's Compensation Commission and directed that the Governor be furnished with a copy.
2. Directed that the Society membership be advised by an article in the Journal of The Arkansas Medical Society of the Section of the Code of Ethics pertaining to appearing on Scientific programs of unapproved groups.
3. Approved the action of the Chairman in signing a contract for Veterans Care for the coming year.
4. Referred to the Committee of Legislation the problem of preventing an influx of doubtfully trained foreign physicians through Canada by way of the Arkansas Homeopathic Medical Board.

The Council met on August 29th and transacted the following business:

1. Referred a report of the abuse of narcotics prescriptions by some physicians to the State Medical Board for action.
2. Voted to express the Society's appreciation to the prosecuting attorney of White County for his part in ending the illegal practice of medicine by an imposter.
3. Referred the matter of a memorial for Mrs. Barton A. Rhinehart to the Committee on Liaison with the Auxiliary.
4. Heard a complaint of the Precision Optical Service, Inc., against the ophthalmologists of Little Rock and appointed a special committee, with legal counsel, to learn the facts in the case, present them to the American Medical Association, and obtain an interpretation of the Code of Ethics as it bears on the situation.

5. Accepted and approved the audit report of the State Medical Board.
6. Directed that a letter of condolence be sent to the family of Dr. Louis E. Gebauer in recognition of the work he had done in the behalf of the practice of medicine.
7. Appointed a special committee to serve as Liaison between the Arkansas Medical Society and the Regional Medical Consultant for the National Foundation for Infantile Paralysis.
8. Voted to direct Arkansas delegates to the American Medical Association to introduce a motion for re-appraisal of the legislative procedure and policy of that organization.
9. Authorized Arkansas delegates to the American Medical Association to present a resolution of commendation of Wilbur Mills for his part in keeping physicians out of Social Security.
10. Considered a bid for printing of the Journal and decided to continue using the present printer.
11. At the request of the Woman's Auxiliary, the Council voted to pay for up to 150 subscriptions to "Today's Health" to be placed in County Bookmobiles and public libraries.
12. Voted not to allow a request for \$100.00 for expenses of a postgraduate course in Industrial Medicine.
13. Directed the Legislative Committee to introduce legislation in the 1955 Arkansas Assembly to consolidate the several medical boards.
14. Decided to call a special meeting of the House of Delegates and membership to discuss legislative policy and to coordinate the action of all of the Society.
15. Voted an increase in salary for the Executive Secretary.

On December 5th, the Council met and conducted the following business:

1. Approved the action of the Executive Committee in appointing L. H. McDaniel to serve as delegate to AMA at its Miami Meeting in place of Earle Hunt, deceased.
2. Noted that, due to death and retirement, there was in fact no Cleveland County Medical Society and, therefore, revoked the charter of that Society.
3. Heard the report of the special committee on the complaint of the Precision Optical Company of Little Rock against the ophthalmologists of that city, which had received the opinion from the American Medical Association that the ophthalmologists in the Little Rock area were not engaged in unethical practice in dispensing eye glasses providing they do not receive a profit from the sale of said eye glasses. The Council voted to commend the committee for its work and to accept and approve its findings.
4. The Council approved an additional legal fee for Mr. Eugene Warren in the amount of \$507.30 for his handling of a special case.
5. Referred to the Committee on Medical Education the complaint of individual pathologists that the University of Arkansas Medical School pathologist was doing work at cut-rate prices which did not include state-provided materials, services of technicians, and rent on building and equipment.

6. Referred to the Committee on Hospitals a resolution by Arkansas Blue Cross-Blue Shield regarding insurance coverage of pathologists, radiologists, and anesthesiologists.
7. Voted to commend the Commission on Mental Health Needs and Resources and accept and approve its report.
8. Voted to advise the Sebastian County Medical Society that it could find no cause for censuring the Editor of the Journal for an article printed in COSMOPOLITAN magazine.
9. Voted to pay vice councilor's mileage for attending Council meetings on the same basis that Councilors are paid.

The Council met on February 20th and transacted the following business:

1. Decided to hold a breakfast meeting at 7:00 A.M., Monday, May 30th, in lieu of the noon meeting usually held.
2. Voted to commend the Garland County Medical Society for its action in defending a suit brought by a Hot Springs physician against the Ouachita General Hospital and assured that County Society of any additional support required.
3. Appointed a committee to select a candidate for the AMA Distinguished Service award.
4. Voted \$25.00 for the Joint Coordinating Commission for the Improvement of Patient care. At that Commission's request, the Council extended the terms of office of two of the medical society representatives to two-year terms and appointed the other member for one year.
5. At the request of the Committee on Industrial Health, the terms of the medical society representatives on the Arbitration Commission were made to coincide with the medical society operating year. The Council also voted to allow the Commission to set up its own rules of operation.
6. The Council voted to notify Frank Riggall of the procedure for formal appeal and to advise him that the Council will consider his case when such an appeal is received.
7. Voted a motion of commendation for Joe Shuffield and Mr. Peter Diesch for their outstanding success with the 1955 Legislature.
8. Referred to the Legislative Committee the problem of opposition to House Bill 66 to place responsibility for enforcement of narcotic laws on the State Board of Health.
9. Because of the formation of the combined medical board, it was necessary for the Council to nominate members for a new board. The length of term of each member was decided by lot and the following names were submitted to the Governor:

First Congressional District—J. Max Roy, Forrest City, 1 year.

Second Congressional District—M. L. Harris, Newport, 6 years.

Third Congressional District—H. J. Hall, Clinton, 2 years.

Fourth Congressional District—G. D. Murphy, Jr., El Dorado, 5 years.

Fifth Congressional District—W. A. Snodgrass, Little Rock, 7 years.

Sixth Congressional District—Frank Burton, Hot Springs, 4 years.

Member-At-Large—Jeff Baggett, Prairie Grove, 3 years.

10. Decided not to make any representations to the Governor with regard to the appointment of a physician to the Board of Trustees of the University of Arkansas.
11. Adopted a resolution thanking E. J. Byrd of Camden for his support of medical legislation in the State Legislature.
12. Directed that letters be sent to the Pulaski County Medical Society recognizing the work of its members in assisting the legislative committee with members of the Arkansas Assembly.

Mr. Peter Diesch read the report of the Legislative Committee:

REPORT OF THE LEGISLATIVE COMMITTEE

JOE SHUFFIELD, Chairman

Since 1903, when the first medical practice act was passed, medical licensure has been provided by three separate boards, the Eclectic, the Homeopathic, and the State Medical Board of the Arkansas Medical Society. The Homeopaths, as an organization, ceased to exist several years ago, and the number of Eclectics has been reduced to less than one hundred, and for some time that board has had no new applications to consider.

Following the direction of the Council and other members of our Society, at a meeting held in Little Rock in December, 1954, there was introduced Senate Bill 62, by Senator Byrd, which became Act 65; 1955, and which abolished the three boards previously existing, and created the Arkansas State Medical Board, consisting of 9 members, of whom 7 shall be appointed by the Governor, on nomination of our Society, one on nomination of the Eclectic Association, and another shall be chosen by those 8, who shall serve as secretary at the pleasure of the board. The Arkansas State Medical board now exercises the only authority by which one can obtain a license to practice medicine in our State.

The increasing recognition of the value of psychiatric treatment, has recently induced charlatans, or other persons without adequate training, to pose as specialists in that field. For that reason, under direction of the gathering previously mentioned, a bill was introduced by Mr. Roscopf of Phillips county, H.B. 135, which added to the definition of the practice of medicine, the phrase "including the diagnosis and treatment of mental and nervous diseases and disorders," and that bill is now the law, being Act 107; 1955. It provoked quite a bit of discussion, particularly from the psychologists, who feared that their right to pursue their work, might be endangered. The Chiropractors also gave us trouble in connection with our bill. Following numerous discussions with the psychologists, by your committee, and psychiatrists of our Society, we assisted the psychologists in the preparation of a bill, which creates a board, and outlines permitted practice by psychologists. We think the enactment of these two bills will effectively control unauthorized practice in that field of medicine. That was H.B. 464, and became Act 129; 1955.

H. B. 96, would have separated the School of Medicine from the University, and set up a separate board for its

administration. Its author, Mr. Van Dalsem, was very persistent in his efforts, but after many conferences with your committee, the Dean, and the Chairman of the Council, he failed to call it up for a vote. It is probable that a similar bill will be introduced at the next session, and we should, in the meantime, give thought to this matter. It might be well for the committee on medical education to make a special study of this question, so as to make a report to the Council, or House of Delegates, prior to January 1, 1957. Appropriations for the Medical Center are now, and probably will continue to be, as large as that for all the balance of the University.

By direction of the gathering previously mentioned, there was introduced S.B. 160, providing that autopsies may legally be performed, when permission is obtained from the person who would be entitled to claim the body for internment, or from any one of such persons. This bill is now the law, and is known as Act 172; 1955.

H.B. 361, now Act 357; 1955, amends the previous law concerning barbiturates, by making it unlawful for any person to procure or possess barbiturates except upon the written prescription, or personal dispensation of a physician, made following a personal contact by such physician, such personal contact to be made upon the occasion of the writing of each such prescription, or the making of each such dispensation. Attempt to obtain the drug by fraud or misrepresentation, by alteration of a prescription, or by the use of a false name, constitutes a misdemeanor, punishable by a fine of not less than \$100, or by imprisonment of not more than one year, or both. The certificate of registration of any pharmacist may be revoked when the registrant is found by the board to be wilfully violating the provisions of this act. This law will probably reduce the number of addicts, and we regard it as highly beneficial. In this connection we recall the enthusiasm of our late, lamented and devoted associate Val Parmley, who was responsible for the enactment of the first barbituratic law, and who insisted that the unrestrained use of the drug was a great evil.

H.B. 66, now Act 155; 1955, by Moody of White, provides for the enforcement of narcotic drug laws by the State Health Officer, and all peace officers and prosecuting attorneys within the State. It is similar to the Federal law, and provides that an apothecary may sell such drugs on a written or oral prescription of a physician, dentist or veterinarian. It will be noted that this legalizes oral prescriptions, which has not heretofore been true, even though it has been the custom. Chiropractors made a determined effort, without success, to have such authorization extended to them.

Loans to medical students may now be repaid by the recipient practicing in a community of two thousand or less, according to the most recent Federal census, for a period of 5 years, dating from completion of internship. Interest at the rate of 4% from date of loan, shall be paid on unpaid balance. Each year of such service shall reduce the amount of the principal by one-fifth of the amount of the loan, and the recipient may, after having spent a minimum of two years practice in such community, elect to pay the unpaid balance of the loan, plus interest, in cash, and be discharged from the obligation. If the recipient fails to finish medical college, or internship, the loan, at the option of the Financing Board, shall at once become due. This was H.B. 215, now Act 69; 1955.

Qualification of the superintendent of the State Hospital for Nervous Diseases, is provided by S.B. 300, now Act 423; 1955. The previous law was practically silent on the subject, and this law is designed to make sure that no

unqualified person obtains that position after our present well-qualified Superintendent is succeeded by another.

H.B. 295, now Act 161; 1955; provides that when the State Health Officer believes that any person has tuberculosis in active state, who will not voluntarily seek a medical examination or treatment, such officer shall determine the environmental conditions of that person, to ascertain if it is proper that he be isolated. When it is believed that such person is a source of danger to others, the State Health Officer shall petition the Circuit Court to order the admission of such person to a State tuberculosis sanatorium. The petition shall be heard in open Court, and if the facts justify such an order, the Court may commit such person to a sanatorium. The Superintendent of the sanatorium may direct that such person be restrained from leaving the institution. A person so committed, who violates the regulations of the sanatorium, may by order of Court, be confined for a period not exceeding 6 months in any place where persons convicted of disorderly conduct may be confined.

H.B. 131 sought to create a department of Occupational licensing. By its provisions, all licensing boards would report their findings to that board, which could thereupon issue or decline to issue, a license. We saw no merit, whatever, in the bill, and opposed it, and it was not called up for passage.

The Cancer Commission appropriation for \$52,790, was passed, as was the appropriation for the Medical Center, in the same amount as the appropriation of two years ago.

The Attorney General recently ruled that a member of the Basic Science Board, who received a salary from the State (as in the case of Dr. Dellinger) could not be paid for conducting examinations and grading papers. We had the pleasure of assisting in the passing of a bill, which was H.B. 586, now Act 428; 1955, which corrected that situation.

Various other bills which we considered harmful, such as the one which would tax professional and other services, had our attention, as we endeavored to carry out the wishes of the Society.

SUPPLEMENT TO REPORT OF SUB-COMMITTEE ON HEALTH AND MEDICAL RESOURCES FOR CIVIL DEFENSE

JOE NORTON, Chairman

Recently the matter of planning, promoting and training of physicians in matters pertaining to atomic, biological and chemical warfare has been placed in the hands of the United States Public Health Service, to utilize the existing administrative and professional set up of that department.

One new phase of this training is to offer to physicians Reserve Officer Commissions in the United States Public Health Service, to insure regular and systematic training of those physicians in the medical aspects of atomic, biological and chemical warfare. Such training would be optional, at government expense, and a free choice would be allowed the Reserve Officer as to what, when and where he might train. Each course would last 1-2 weeks.

A matter of interest for those physicians in draft status is the fact that any Reserve Officer in the Public Health Service who is drafted could elect to serve his period of active service in the United States Public Health Service rather than in other branches of Federal Medical Service. Generally Reserve Public Health Officers would not be

called to an active period of service except in dire, extreme and general emergency.

Further information on this matter can be obtained from your chairman, or from Dr. John Herron, State Health Officer, Little Rock, or from Dr. Maurice Roe, Regional Public Health Director, Dallas, Texas.

Dr. Roe has available pertinent information concerning this matter and other matters of medical aspects atomic, biological and chemical warfare, and, if the Arkansas Medical Society will approve, he will be glad to further contact individually, by mail, the members of our State Society.

SUPPLEMENTAL REPORT OF THE SUB-COMMITTEE ON MENTAL HEALTH

E. H. CRAWFIS, Chairman

The Sub-committee (Dr. Reese and Dr. Crawfis) participated with Dr. Shuffield on a public hearing of the amendments to the Medical Practice Act when they were considered by the Public Health Committee of the Arkansas Legislature. This bill, which amended the Medical Practice Act in order to clearly include the diagnosis and treatment of mental and nervous disorders in the practice of medicine, was recommended favorably by both committees of the House and Senate, was passed by the Legislature and is now a law. At the time of this hearing the amendments were opposed by representatives of the psychology profession. As a result of this opposition, a series of meetings were called by Dr. Shuffield in which the sub-committee participated, together with representatives of the Arkansas Psychiatric Society and the Arkansas Psychological Association. Legislation was drafted to provide for the licensing of psychologists and the establishment of a Psychology Board of Examiners. As a result of this activity, the psychologists' opposition to the Medical Practice Act was withdrawn and Dr. Shuffield supported the bill of licensing psychologists. This bill also passed the Legislature, was signed by the Governor, and goes into effect July 1, 1955.

Because of the provisions of this bill, which require a close working relationship between the medical profession and the psychology profession, with medical supervision of cases under psychotherapy by psychologists, the sub-committee recommends that the medical profession in Arkansas familiarize themselves with the provisions of the act licensing psychologists.

LIAISON WITH WOMAN'S AUXILIARY

CHARLES R. HENRY, Chairman

The Advisory Committee for the Auxiliary to the Arkansas Medical Society wishes to compliment the ladies for the superior accomplishments of the past twelve months. The interest, the effort, and the enthusiasm exhibited have been truly remarkable.

An important reorganization of leadership was made this year. Five Regional Vice-Presidents were appointed, each of whom had several counties under her jurisdiction. Regional conferences were held with good attendance reported.

Five future nurses clubs were organized this year—only one existed a year ago. Other projects include sponsoring of a Film Fair in connection with Mental Health Week, participation in the Chamber of Commerce Health Week, and television programs which were shown in Ft. Smith, Texarkana, and Pine Bluff.

The Woman's Auxiliary has worked faithfully as a sponsor of the annual Rural Health Conference. They have contributed largely to the success of the program.

The Public Relations Committee of the Arkansas Medical Society was instrumental in stimulating the organization of the Arkansas Medical Assistants Society. The Woman's Auxiliary was called to assist in this activity and they have given generously of both time and money to promote this group.

The membership of the Woman's Auxiliary has increased to 743. The Woman's Auxiliary to the Arkansas Medical Society is one of the outstanding auxiliaries in the United States. It has attracted attention because of the virility of its organization, the character of its projects, and because of the seriousness and sincerity its members have as constructive helpers to the Medical profession. The good judgment with which they have conducted their affairs has made the job of the Advisory Committee very easy and pleasant.

G. W. S. Ish, delegate from Pulaski County, expressed the appreciation of the Colored physicians of Arkansas for the respect shown them by the Arkansas Medical Society in inviting them to become members.

Monfort presented the following Constitutional Amendments, approved at the 78th Annual Session, for final adoption:

CHAPTER I. ADDITION TO SECTION 4:

An annual affiliate membership may be granted interns and residents who have been recommended as such by the individual County Medical Society in which the internship and residency is located. This type of member shall be accorded full privileges, except that he may not vote, and he shall receive the Journal of the Arkansas Medical Society.

CHAPTER VIII. SECTION 1:

- (a) Delete "Veterans Administration" from the 6th Committee of Public Relations.
- (b) Add after "8. Committees on Arrangements," and before the Section a and b of Section I, 9, "Committee on Veterans Administration Affairs."

Upon motion (Martin, Richardson) the House gave final approval to the Amendments.

G. H. Landers presented the following resolution which was referred to Reference Committee Number Two:

"The Arkansas Radiological Society now has an active membership of thirty, serving a great proportion of the hospitals throughout the state.

"The members of the Arkansas Radiological Society desire to have an annual scientific meeting in order to promote a better understanding of the science of Radiology among its own members and the other doctors of the State of Arkansas.

"It is the opinion of the Radiological Society that such a meeting be held at the time and place of the Annual Meeting of the Arkansas State Medical Society.

"RESOLVED, that a section on Radiology be formed as a component part of the Arkansas Medical Society by so altering the constitution of the Society."

The speaker announced that terms of members of the State Board of Health from the Third and

Sixth Congressional Districts would expire and that meetings of members from those districts had been previously announced.

In meetings on the floor by Councilor districts, the delegates selected the nominating committee as follows:

FIRST DISTRICT: Milton D. Deneke, West Memphis; SECOND DISTRICT: O. J. T. Johnston, Batesville, Chairman; THIRD DISTRICT: E. D. McKnight, Brinkley; FOURTH DISTRICT: H. T. Smith, McGehee; FIFTH DISTRICT: Joe B. Wharton, Jr., El Dorado; SIXTH DISTRICT: R. C. Dickinson, Horatio; SEVENTH DISTRICT: Euclid M. Smith, Hot Springs; EIGHTH DISTRICT: Elvin Shuffield, Little Rock; NINTH DISTRICT: D. L. Owens, Harrison; TENTH DISTRICT: James M. Kolb, Clarksville.

The House adjourned at 5:30 P.M.

Monday Evening, May 30th

The Garland County Medical Society entertained with an informal party at the Majestic Lodge on Lake Hamilton. Monday afternoon and night the dancing, motor boating, and swimming were enjoyed by a great number of members and guests.

SECOND GENERAL SESSION

Tuesday, May 31st, 9:00 A.M., Ballroom

The meeting was called to order by Vice President Eldon Fairley and proceeded as follows:

James T. Priestley, Rochester, Minnesota, "Surgical Treatment of Pancreatitis."

Henry Swan, Denver, Colorado, "Cardiac Arrest."

Carroll Larson, Iowa City, Iowa, "The Non-Operative Management of the Problem of the Backache."

E. H. Watson, Ann Arbor, Michigan, "Points Often Overlooked in Examining Children."

O. T. Bailey, Indianapolis, Indiana, "Recent Advances in the Basic Sciences."

MEMORIAL SERVICE

Tuesday, May 31st, 11:30 A.M., Ballroom

President Brooksher presided at the Memorial Service honoring members who passed away during the year.

The invocation was given by the Reverend John L. Dodge, First Baptist Church, Hot Springs.

Mrs. Louise Hickman sang a hymn.

John Wm. Smith gave the memorial address:

IN MEMORIAM

We come humbly and reverently to honor and pay tribute to the memory of our friends who have passed from us since we last met. We extend our sincere sympathy to

their families, and to those whom they have served so conscientiously and faithfully.

Today we share a common sorrow, but this common sorrow binds us more closely together. In the passing of these 36 physicians, our medical profession has suffered a distinct loss. Our State has lost distinguished leaders. These men were beloved and respected both as physicians and as civic and church leaders. Their lives were selfless and dedicated to the service of their fellowmen. Their characters were molded of the finest qualities of humility, responsibility, loyalty, personal sacrifice and devotion to duty. Their's were lives of purpose and usefulness. Philip Brooks said, "To find our duty certainly and somewhere, somehow to do it faithfully, makes us good, strong, happy and useful men and tunes our lives into some feeble echo of the life of God." Our friends had this sense of duty—wherever it called they answered. They literally gave themselves for the well being of their people, and the heavy strain of their profession has taken its toll.

When we would understand the great love of God we call Him "Father." When we would understand the love of the Master, His desire to heal the sufferings of all mankind, we call Him "The Great Physician, the Master Physician." We do this because we know and understand what the ministrations of our earthly physicians mean to us. What greater tribute can be paid to our profession, what more exalted standard can be raised for us to live up to?

The Master also set the standard of greatness when He said, "Let him who would be great be the servant of all." The medical profession perhaps more nearly exemplifies this standard of greatness than does any other. For our profession, unlike most others, knows no creed, race or color. We serve the clean and the unclean, the rich and the poor alike. The more tragic the condition, the more is the heart and mind of a doctor challenged to try to relieve suffering. When these our friends met the Master they could truthfully say, "We cared for the sick and the suffering, the poor, the lame, the halt and the blind." Then did the Master answer, "Inasmuch as ye did it unto the least of these, my people, ye have done it unto me. Enter into my Kingdom and receive your reward, which has been prepared for you. Great is your reward, Eternal Life."

These friends of ours whom we honor today do not need cold monuments of stone erected to their memory. They have countless living monuments in whose memory they will be forever enshrined. They are the many who have been restored to health and their span of life increased, the precious lives of children that have been saved through their professional skill and knowledge. Too, their work and accomplishments in the many associations and organizations for the welfare of humanity will always be remembered and appreciated, and will stand for all time as a monument to their memory.

The Bible teaches us that life on earth is but a preparatory school to make us ready for our future life, to which all of us must go when the period of training is over here. Our friends whom we honor today completed their lower education, and have now enrolled in the 1954-55 class in the College of Eternal Life. They have reported to the Master Physician for their new assignment. A higher life, a higher education, a greater service is now theirs.

Today when we think of the phase of life that we speak of as Death, we no longer feel it necessary to defend or prove immortality. Science and religion agree in the belief that at death the soul does not die. Only recently an eminent scientist said, "According to the minimum standards of science we are prepared to declare the soul

theory has been proved." This statement may ultimately be regarded as the greatest scientific declaration of the twentieth century. That which in the past we have had to take on faith, "That life is ever Lord of Death and love can never lose its own," is now being confirmed.

A few years ago Peter Marshall asked his congregation, "Are you scared of death?" "I'm not. I'm looking forward to it. I can hardly wait. I know that one day I must die. If the need should come tomorrow that I go, I go in peace." Peter Marshall's last words to his wife were, "I will see you in the morning."

Sleep is but the little sister of death, for the Master said, "He is not dead, he is asleep." At night, tired and worn out with the burdens of the day, we fall asleep, rest comes, burdens disappear, we awaken in the morning rested, refreshed, ready to take up life anew. God in His graciousness and wisdom anticipated our need, and has given us the great blessing of sleep. The time comes in every life when we are worn out with life's cares, our physical bodies can no longer stand the strain, and then we lie down to the great sleep, to awaken to a new life in our Father's house. God in His wisdom and kindness has provided for us the sleep of death, which is but the method of transportation to our Father's house.

Peter Marshall told the story of an only son who was ill with leukemia. Month after month the mother cared for him, read to him, and played with him, hoping to keep him from realizing the finality of the doctor's diagnosis. But as weeks and months went by the little boy gradually began to understand that he could never be like the other boys whom he saw from his window, and, small as he was, he began to understand the meaning of death and he knew, too, that he was going to die. One day his mother had been reading to him about King Arthur and his Knights of the Round Table, of Lancelot and Guinevere and Elaine, and of that last battle in which so many of the Knights had met their death. As she closed the book the child sat silent for a moment and then asked a question that had been weighing on his heart: "Mother, what is it like to die? Mother, does it hurt?" Quick tears came to the mother's eyes, and she hurriedly left the room, supposedly to see about something on the stove. She knew it was a question with deep significance. She knew that it must be answered carefully, wisely. So she prayed that the Lord would keep her from breaking down before her son, and would tell her how to answer him. The Lord did tell her. Immediately she knew just how to answer the question. When she returned to his room she said, "You remember when you were a tiny boy how you used to play so hard all day that when night came you would be too tired even to undress, and you would tumble into Mother's bed and fall asleep? It was not your bed—it was not where you belonged. In the morning, much to your surprise, you would wake up and find yourself in your own bed in your own room. You were there because someone had loved you and taken care of you. Your father with big, strong arms had carried you away. Death is just like that. We just wake up some morning to find ourselves in the other room—our own room where we belong—because the Lord Jesus loved us."

Arthur Brisbane pictured a crowd of grieving caterpillars carrying a dead cocoon to its final resting place. The poor distressed caterpillars were weeping and heartbroken, but all the while the lovely butterfly fluttered happily over their heads.

Let us not think of our loss, but of their gain. Let us not think of their going away, but of their arriving. As

the voice of Death whispers, "You must go from the earth," let us hear the voice of the Master say, "You are but coming to Me."

To us our friends have bequeathed an inspiring legacy, the noble example of their lives, their unstinting loyalty and devotion to their people, and unselfish to those in need. "May we so live that when our summons comes to join that innumerable caravan" that we shall go as nobly as they.

With Paul, our beloved colleagues can say, and we can say of them, "They have fought a good fight, they have finished their course, they have kept the faith: Henceforth there is laid up for them a crown of righteousness."

And so we say,

"Life's race well run,
Life's work well done,
Life's crown well won."

President Brooksher read the names of the departed:

E. E. Baker, Dermott, May 30, 1955
J. J. Baker, Magnolia, July 25, 1954
James R. Barnett, Arkadelphia, July 7, 1954
S. S. Beaty, England, August 4, 1954
Gibbs Biscoe, Dumas, December 25, 1954
H. D. Bogart, Marianna, November 13, 1954
Joseph P. Bremer, Point Cedar, June 12, 1954
Robert L. Bryant, Arkadelphia, May 29, 1955
C. B. Capel, Pine Bluff, June 12, 1954
C. K. Carruthers, Pine Bluff, October 21, 1954
A. E. Cox, Helena, August 16, 1954
S. W. Douglas, Eudora, August 12, 1954
W. G. Hancock, Rison, November 13, 1954
E. J. Highfill, Cave Springs, January 21, 1955
G. F. Hollingsworth, Dyess, July 20, 1954
Wm. H. Horn, Magnolia, September 14, 1954
Earle H. Hunt, Clarksville, November 15, 1954
O. H. King, Hot Springs, June 14, 1954
Charles G. Leverett, McGehee, March 2, 1955
Richard W. Miller, Fayetteville, January 18, 1955
D. K. McCurry, Green Forest, May 16, 1954
J. F. McKnight, Bradley, August 21, 1954
M. L. Norwood, Lockesburg, October 7, 1954
W. C. Overstreet, Jonesboro, December 3, 1954
J. W. Ramsey, Jonesboro, December 6, 1954
D. A. Rhinehart, Little Rock, May 23, 1954
John Seamans, Mansfield, May 25, 1954
T. E. Souter, McNeil, August 28, 1954
S. A. Southall, Lonoke, October 14, 1954
J. S. Stell, Hot Springs, July 31, 1954
J. Brooks Tate, Texarkana, March 18, 1955
W. H. Toland, Nashville, April 11, 1955
Wylie E. Turner, Sr., Piggott, February 3, 1955
J. A. Van Beber, Gassville, November 21, 1954
Floyd Webb, Blytheville, May 28, 1954
E. O. White, Hamburg, March 31, 1955

President Brooksher read the names of the following deceased members of the Woman's Auxiliary:

Mrs. J. F. McKnight, Bradley.
Mrs. B. A. Rhinehart, Little Rock.

Joseph A. Norton sang "Going Home."

Reverend Dodge pronounced the benediction.

Here and There at the Convention



PEDIATRICS

The Section on Pediatrics held a luncheon meeting in the Montagu Room. Barney Briggs of Little Rock presided. After a short recess, the group reconvened for a symposia with James T. Rhyne presiding and E. H. Watson, Roger Bost, and William F. Barron participating.

SURGERY

The Section on Surgery held a luncheon meeting in the Fountain Room with H. W. Thomas as Chairman. James T. Priestley, Henry Swan, Carroll Larson, and O. T. Bailey participated in the symposia which followed.

EYE, EAR, NOSE AND THROAT

The Section on Eye, Ear, Nose, and Throat convened at 10:00 A.M. The morning program consisted of an address by the Chairman K. W. Cosgrove and a paper by Peter C. Kronfeld. Luncheon was served in the same room, followed by talks by Charles Watkins and Samuel Fomon of New York.

Tuesday Evening, May 31st

The Annual Dinner and Dance was held in the Main Dining Room beginning at 7:15 P.M. Three hundred and fifty-five members, wives, and guests enjoyed the food and the dinner music by the Hotel Orchestra.

President Brooksher presented appropriately engraved silver trays to Mrs. Mason Lawson and Mrs. Louis K. Hundley, President-Elect of the Woman's Auxiliary to the American Medical Association and President of the Woman's Auxiliary to the Southern Medical Association, respectively. President Brooksher in his remarks called attention to the honor and prestige which the leadership of Mrs. Lawson and Mrs. Hundley had brought to Arkansas.

Prizes were awarded those who participated in the Society's Golf Tournament, first prize for low net score going to L. J. Harrell of Prescott.

After dinner, the Orchestra furnished dance music until 1:00 A.M.

Wednesday, June 1st

With Lewis Tilley presiding, a symposium on "What's New" was held beginning at 9:00 A.M.

Speakers were: David Yocum, "Surgery"; William Jordan, "Neurology"; W. D. Thornton, "Obstetrics and Gynecology"; Joseph L. Rosenzweig, "Pediatrics"; Joseph Norton, "Radiology"; Art Martin read a paper on "Clinical Pathology" by A. S. Koenig.

FINAL SESSION**HOUSE OF DELEGATES**

Wednesday, June 1st, 1955, 1:30 P.M.

The House of Delegates was called to order by Speaker Brown. The following delegates and members seated as delegates by action of the House were present:

BENTON, Kenneth A. Siler; BOONE, D. L. Owens; BRADLEY, George Wynne; CHICOT, H. W. Thomas; CLARK, Jack N. Kennedy; COLUMBIA, Charles Weber; CRAIGHEAD-POINSETT, J. H. McCurry, Joe Verser; CRAWFORD, J. W. Redman; CRITTENDEN, Milton Deneke; CROSS-ST. FRANCIS, Gordon L. Duckworth; FRANKLIN, C. C. Long; GARLAND, H. King Wade, Sr., H. King Wade, Jr., Frank Adams, Thomas Durham; GREENE-CLAY, A. H. Mad-dox; HOWARD-PIKE, Uthel L. Smith; INDEPENDENCE, O. J. T. Johnston; JEFFERSON, Howard S. Stern; JOHNSON, James M. Kolb; LAWRENCE, J. B. Elders; MILLER, Charles P. Yarbrough; MISSISSIPPI, Eldon Fairley; MONROE, J. P. Williams, Jr.; NEVADA, J. B. Hesterly; OUACHITA, Henry Hearnberger; PHILLIPS, Reuben L. Chrestman; POPE-YELL, J. Arnold Henry, Roy I. Millard; PULASKI, Gordon P. Oates, Robert D. Jones, Bill Dave Stewart, Joe Norton, Edgar J. Easley, G. W. S. Ish, Edwin F. Gray, Joe Shuffield; SEBASTIAN, S. Wright Hawkins, Art B. Martin, L. A. Whittaker; SEVIER, Charles N. Jones; UNION, J. B. Wharton, Jr., Warren S. Riley; WASHINGTON, Coy C. Kaylor, P. L. Hathcock; WHITE, Wm. L. Davis.

The report of Reference Committee Number One was read by its Chairman, C. C. Long:

Reference Committee Number One met during the Annual Session at the Hotel Arlington on May 31st, 1955, and considered the various committee reports which have been submitted to us.

The Committee reports as follows:

It recommends approval of the following committee reports as presented in the March and May, 1955, issues of the Journal of the Arkansas Medical Society.

1. Scientific Program for Annual Session of the Arkansas Medical Society.
2. Arrangements for Annual Session.
3. Advisory Committee to Selective Service.
4. Report of the State Medical Board.
5. Annual Report of the State Health Department.
6. Third Councilor District Professional Relations Committee.
7. Sixth Councilor District Professional Relations Committee.
8. Eighth District Professional Relations Committee.
9. Tenth District Professional Relations Committee.

10. The Arkansas State Cancer Commission.
11. Liaison with the Nursing Profession.
12. Report of the Executive Secretary.
13. Report of the Committee on Medical Education.

The Reference Committee wishes to call attention to the following typographical errors in the following reports as printed in the Journal.

1. Title of "Advisory Committee to Advisory Service," should read "Advisory Committee to Selective Service."
2. Report of the State Medical Board of the Arkansas Medical Society, "final figure of expenditures, bonds, and cash balance," should read "\$34,722.22" instead of "\$34,722.82."
3. Report of the Committee on Medical Education of the Arkansas Medical Society. The last paragraph should read "it at least appears at this time," instead of "it at last appears."

The committee recommends approval of the Resolution concerning the ownership of drug stores and the dispensing of drugs and appliances by licensed physicians.

Reference Committee Number One calls attention to the fact that little or nothing of controversial nature was contained in the committee reports submitted to us.

Upon motion of Long, Murry, the House adopted the report of Reference Committee Number One.

The report of Reference Committee Number Two was read by Jack Kennedy for H. W. Thomas:

Reference Committee Number Two met during the Annual Session of the Arkansas Medical Society at the Arlington Hotel, Hot Springs, Arkansas, on 31st of May, 1955, and considered the various committee reports and resolutions which had been referred to it.

The Committee reports as follows:

It recommends approval of the following committee reports as published in the March, 1955, Journal of the Arkansas Medical Society and as later amended before the House of Delegates.

1. Public Health.
2. Sub-Committee on Rural Health.
3. Sub-Committee on Mental Health.
4. Polio Advisory Committee.
5. The American Medical Education Foundation.
6. Cancer Control.
7. Industrial Health Committee.
8. Committee on Tuberculosis.
9. Liaison with State Board of Health.
10. Sub-Committee on Postgraduate Education.
11. Budget.
12. Liaison with Blue Cross-Blue Shield.
13. Sub-Committee on Civil Defense.

In addition, Reference Committee Number Two considered the Report of the Committee on Liaison with the Woman's Auxiliary to the Arkansas Medical Society and recommended its approval. The report is attached herewith. The Reference Committee also considered and rec-

ommends approval of the resolution of the Arkansas Radiological Society relative to the formation of a section on Radiology as a component part of the Arkansas Medical Society.

Upon motion of Thomas, Fairley, the House adopted the report of Reference Committee Number Two.

Louis K. Hundley, Chairman, read a supplementary report of the Council:

The Council met at 8:00 P.M., May 29th, 1955, at the Arlington Hotel in Hot Springs, and transacted the following business:

1. Chairman Hundley announced a vacancy occurring on the Board of Trustees of the Blue Cross-Blue Shield Plan beginning January 31st, 1956, with the expiration of the term of Thomas Foltz of Fort Smith. Upon nomination by Kolb, seconded by White, A. S. Koenig of Fort Smith was unanimously elected to the position.
2. Chairman Hundley announced that the terms of office on the Arkansas State Arbitration Commission of N. B. Daniel and D. L. Owens had expired. Upon motion of Murry, seconded by Richardson, Dr. Daniel and Dr. Owen were elected to succeed themselves.
3. Upon motion of Verser, seconded by Roy, Dr. Thomas Price was elected to serve on the Third District Professional Relations Committee.
4. Upon motion of Monfort, second by E. Shuffield, the Council authorized the Chairman to renew the Society contract with the Veterans Administration.
5. Upon motion of Kolb and Wade, Jr., the Executive Committee of the Council was authorized to cash Government Bonds owned by the Society which have matured and have ceased to draw interest. The Executive Committee was authorized to re-invest the bonds as they saw fit commensurate with safety of the principal.
6. After study of the applications to the Pulaski County Medical Society of members of the disbanded Prairie County Medical Society, the Council voted to adhere strictly to the Constitution and request the members from Prairie County to join societies in counties contiguous to Prairie County.
7. The Council studied the documents presented by Dr. Frank Riggall of Washington County accompanying his appeal of the action of that county medical society in refusing him membership. Upon the motion of Richardson, second by Verser, the Council directed that the Chairman appoint a committee of the Council to confer with attorneys and to study Dr. Riggall's appeal and report its findings to the Council in the near future. Appointed on this committee were: Elvin Shuffield, Chairman; Fount Richardson and Joe Verser.
8. The Chairman, with the approval of the Council, appointed a committee to consider the various resolutions which had been presented for its consideration. The committee is composed of: Hugh R. Edwards, Chairman; H. W. Thomas, and R. C. Dickinson.
9. Chairman Hundley read a letter from the Woman's Auxiliary to the Arkansas Medical Society expressing appreciation for the memorial donations to the Ilse

F. Oates Student Loan Fund. Upon motion of Monfort, second by Kolb, the Council voted that such donations be continued in the future.

10. Discussed the situation at the Medical Center in Little Rock and the problems of administration of the Center under established University and Board of Trustee procedures which have led to the resignation of Dean Nicholson.

Upon the motion of Brooksher and Kolb, the Council voted to appoint a special committee to study the administrative relationship of the University and the Medical Center.

11. The Council moved that a resolution commending the work of the Lay Advisory Committee to the University of Arkansas Medical Center be presented to the House of Delegates for its approval and release to the press.
12. A resolution commending the excellent work of Dean Nicholson in the scientific organization and legislative fields, as well as his relations with the physicians of Arkansas, was recommended for consideration by the House of Delegates.
13. Upon the motion of Brooksher and E. Shuffield, the Council requested that a resolution of commendation for Dr. Jonas Salk be drawn up.

The Council met at 7:00 A.M., Monday, May 30th, at the Arlington Hotel in Hot Springs and transacted the following business:

1. Nominated James M. Kolb to fill the unexpired term of Earle Hunt as alternate delegate to the American Medical Association.
2. Heard a discussion by John Herron, State Health Officer, regarding the Salk vaccine. Dr. Herron also spoke on the reporting of vital statistics by Arkansas physicians. He asks that some action be taken by the Society in cases where a physician refuses to file a birth or death certificate.

Upon motion of Kolb and Edwards, the Council voted to recommend that the State Health Department be designated as the agency to distribute the Salk Polio Vaccine with the advice of the Polio Advisory Committee of the Arkansas Medical Society.

Upon the motion of Brooksher and Kolb, the Council voted that an educational program be begun among Arkansas doctors regarding their responsibility in signing birth and death certificates. Such Educational program to be carried on through the Medical Education Committee and publication in the JOURNAL.

The Council met on Tuesday at noon, May 31, 1955, at the Arlington Hotel in Hot Springs, and transacted the following business:

1. Heard a report of the Committee in charge of the Bill Brooksher Student Loan Fund, complimented them on the continued growth of the fund, and directed that work be continued to enlarge it as rapidly as possible.
2. Accepted and approved the audit report submitted by the Treasurer of the Arkansas Medical Society.
3. Approved and referred to the House of Delegates for further action the applications for life membership of the following members:

J. E. Cox, Rosston; C. W. Dixon, Gould; A. J. Harrison, Springdale; Finis E. Rushing, Augusta.

4. Approved and referred to the House of Delegates for further action the applications for affiliate membership for the following members:

W. A. Fowler	H. A. Higgins
Frank Gordon	J. E. Stevenson
Frank Norwood	Wm. I. Porter
Wm. C. Hays, Jr.	James O. Porter
H. L. Brown	Jack E. Mobley
J. L. Parker	O. R. Holloway
Guy Hodges	Howard Kitchens
L. H. Lanier	Wm. R. Meredith
Shelby Atkinson	Loren O. Bohnen
James B. Strachan	Paul H. Woods
T. E. Burgess	Neil E. Crow
S. T. W. Cull	Walter L. Sims
DeWell Gann, Jr.	Wm. K. Bell
Daniel Hardeman	Anthony DePalma
Pat Murphy	Charles Bloom
Jessie Savin	Owen W. Beard
James Scarborough	A. S. J. Clarke
James R. Wayne	Vance J. Crain
A. C. Curtis	John B. Kirkley
Hal Dildy	Wm. R. Lee
Edward R. Duty	John P. McAlister
Cleon A. Flowers	H. P. McDonald
Frank S. Forman	Louis R. McFarland
Jesse Kent Grace	Dallas D. Miles
Oscar Gray, Jr.	Elsy L. Milner
Joe Bill Hall	John Warren Murry
James Clyde Hart	Robert Nixon
B. E. Holmes	Warren J. Roberts
James E. Jernigan	Henry Rogers
Curtis Jones, Jr.	Albert Rosendale
Ralph Joseph	Vernon E. Sammons
George R. Steinkamp	Wm. D. Sessoms

5. Appointed the following members to the committee to study the administrative relationship of the University and the Medical Center:

Joe Shuffield, Chairman; H. W. Thomas, James M. Kolb, H. King Wade, Jr., H. T. Smith, Wayne Workman, and Eugene R. Warren, Legal Consultant.

6. Approved and endorsed the American Association of Physicians and Surgeons Essay Contest.

The Council met at 12:00 Noon on June 1st, 1955, at the Arlington Hotel in Hot Springs, and transacted the following business:

1. Approved the following resolutions and referred them to the House of Delegates for action (See House of Delegates):
2. Voted to commend H. King Wade, Jr., for the work of his committee in arranging this excellent meeting of the Arkansas Medical Society.
3. Voted to refer to the Committee on Constitutional Revision, the Constitution of the Arkansas Commission for the Improvement of Patient Care for its study and recommendations.
4. Heard President of University of Arkansas discuss problems of University Medical Center.

Upon motion (Hundley, K. Wade, Sr.) the House accepted and approved the report of the Council.

O. J. T. Johnston presented the report of the Nominating Committee:

FOR PRESIDENT-ELECT:

Fount Richardson, Fayetteville.
Euclid Smith, Hot Springs.

FOR FIRST VICE-PRESIDENT:

Roy I. Millard, Russellville.

FOR SECOND VICE-PRESIDENT:

Leeman H. King, Hot Springs.

FOR THIRD VICE-PRESIDENT:

Warren S. Riley, El Dorado.

FOR TREASURER:

John Wm. Smith, Little Rock.

FOR SECRETARY:

J. J. Monfort, Batesville.

FOR SPEAKER OF THE HOUSE OF DELEGATES:

T. Duel Brown, Little Rock.

FOR VICE-SPEAKER OF THE HOUSE OF DELEGATES:

C. C. Long, Ozark.

FOR DELEGATE TO AMERICAN MEDICAL ASSOCIATION:

R. B. Robins, Camden.

FOR ALTERNATE DELEGATE TO AMERICAN MEDICAL ASSOCIATION:

R. C. Dickinson, Horatio.

FOR COUNCILORS AND VICE-COUNCILORS:

First District: Joe Verser, Harrisburg, Councilor; Wayne Workman, Blytheville, Vice Councilor.

Third District: J. Max Roy, Forrest City, Councilor; J. P. Williams, Jr., Brinkley, Vice Councilor.

Fifth District: Perry Dalton, Camden, Councilor; Henry Hearnberger, Stephens, Vice Councilor.

Seventh District: H. King Wade, Jr., Hot Springs, Councilor; Randolph Ellis, Malvern, Vice Councilor.

Ninth District: Ross Fowler, Harrison, Councilor; Stanley Applegate, Springdale, Vice Councilor.

Upon motion by H. T. Smith, Murry, all nominees other than those for President-Elect were elected by acclamation.

Written ballots were cast and the tellers reported that Fount Richardson had been elected President-Elect.



President L. H. McDaniel, Tyronza; President-Elect Fount Richardson, Fayetteville; First Vice-President Roy I. Millard, Russellville; Third Vice-President Warren S. Riley, El Dorado.

Mr. Schaefer presented the names of the nominees for the State Board of Health selected by the Third and Sixth Congressional District membership:

Third District:

D. W. Goldstein, Fort Smith; Loyce Hathcock, Fayetteville; C. C. Long, Ozark.

Sixth District:

J. P. Price, Monticello; C. W. Dixon, Gould; H. T. Smith, McGehee.

Upon motion by Kolb, Verser, the House approved the list of nominees.

The House adjourned sine die at 4:00 P.M.

FINAL GENERAL SESSION

June 1st, 1955, 4:00 P.M.

President Brooksher called the meeting to order and presented the Past Presidents seated on platform.

President Brooksher requested J. M. Kolb and R. C. Dickinson to escort President-Elect McDaniel to the rostrum where he took the oath of office as administered by President Brooksher.

President McDaniel thanked the members for honoring him and expressed the hope that the Society would continue to work for the benefit of mankind.

At the request of the President, J. M. Kolb and R. C. Dickinson escorted President-Elect Richardson to the rostrum where he was presented to the Society. Richardson spoke briefly thanking the members for their confidence in him.

Elvin Shuffield, on behalf of the Pulaski County Group, extended an invitation to the Society to hold its 1956 meeting in Little Rock. Upon motion by Verser and Long, the Society voted to accept the invitation.

The Society adjourned its 79th Annual Meeting at 4:30 P.M.

COUNCIL MEETING

The new Council met immediately following adjournment of the General Session. Louis K. Hundley was elected chairman for the ensuing year by acclamation.

Fount Richardson was re-elected Editor of the Journal.

PAST PRESIDENTS' BREAKFAST

June 1st, 1955, Arlington Hotel, Hot Springs



Front Row, left to right—S. J. Allbright, L. T. Evans, W. H. Mock, O. T. J. Johnston, Geo. B. Fletcher.
Standing—R. C. Dickinson, H. T. Smith, H. Fay H. Jones, Euclid Smith, H. King Wade, Sr., Joe F. Shuffield.

Joe Shuffield and Mr. Warren, speaking for the special committee appointed to study the administration of the Medical School, asked approval of the committee's plan to ask the University Board of Trustees for a meeting to discuss problems of the Medical Center. By unanimous vote the Council approved the plans as presented.

ATTENDANCE

Members	455
Visitors	78
Auxiliary	205
	<hr/>
	738

OFFICERS OF THE ARKANSAS
MEDICAL SOCIETY—1955-1956

President.....	L. H. McDaniel, Tyrnza
President-Elect—	
	Fount Richardson, 316 W. Dickson, Fayetteville
First Vice-President—	
	Roy J. Millard, 511 W. Main, Russellville
Second Vice-President—	
	Leeman H. King, Medical Arts Bldg., Hot Springs
Third Vice President—	
	Warren S. Riley, 302 Schuler Bldg., El Dorado
Secretary.....	J. J. Monfort, Batesville
Treasurer.....	John Wm. Smith, 1415 W. 6th St., Little Rock
Delegates to A.M.A.—	
	W. R. Brooksher, Fort Smith; R. B. Robins, Camden
Alternate A.M.A. Delegates—	
	J. M. Kolb, Clarksville; R. C. Dickinson, Horatio
Speaker, House of Delegates—	
	T. Duel Brown, 516 Medical Arts Bldg., Little Rock
Vice Speaker.....	C. C. Long, Ozark
Journal Editor—	
	Fount Richardson, 316 W. Dickson, Fayetteville

EXECUTIVE COMMITTEE OF THE COUNCIL

Chairman.....	Louis K. Hundley, 316 National Bldg., Pine Bluff
President.....	L. H. McDaniel, Tyrnza
President-Elect—	
	Fount Richardson, 316 W. Dickson, Fayetteville
Secretary.....	J. J. Monfort, Batesville

MEDICAL COUNCILOR DISTRICTS

First District

Councilor.....	Joe Verser, Harrisburg
Vice Councilor.....	Wayne Workman, Blytheville
	Clay, Craighead, Crittenden, Fulton, Greene, Lawrence, Mississippi, Poinsett, Randolph and Sharp.

Second District

Councilor.....	Hugh R. Edwards, Searcy
Vice Councilor.....	John Sneed, Conway
	Cleburne, Conway, Faulkner, Independence, Izard, Jackson, Stone and White.

Third District

Councilor.....	J. Max Roy, Forrest City
Vice Councilor.....	J. P. Williams, Jr., Brinkley
	Arkansas, Cross, Lee, Lonoke, Monroe, Phillips, Prairie, St. Francis and Woodruff.

Fourth District

Councilor.....	Louis K. Hundley, 316 Nat'l Bldg., Pine Bluff
Vice Councilor.....	H. W. Thomas, Dermott
	Ashley, Chicot, Desha, Drew, Jefferson and Lin- coln.

Fifth District

Councilor.....	Perry Dalton, Camden
Vice Councilor.....	Henry Hearnberger, Stephens
	Bradley, Calhoun, Cleveland, Columbia, Dallas, Ouachita and Union.

Sixth District

Councilor.....	Harry E. Murry, 320 East 5th St., Texarkana
Vice Councilor—	
	Charles Yarbrough, 1901 Hickory, Texarkana
	Hempstead, Howard, Lafayette, Little River, Mil- ler, Nevada, Pike, Polk and Sevier.

Seventh District

Councilor.....	H. King Wade, Jr., Wade Clinic, Hot Springs
Vice Councilor.....	Randolph Ellis, Malvern
	Clark, Garland, Grant, Hot Spring, Montgomery and Saline.

Eighth District

Councilor....	H. Elvin Shuffield, Donaghey Bldg., Little Rock
Vice Councilor—	
	Robert D. Jones, 311 Waldon Bldg., Little Rock
	Pulaski.

Ninth District

Councilor.....	Ross Fowler, Harrison
Vice Councilor.....	Stanley Applegate, Springdale
	Baxter, Benton, Boone, Carroll, Madison, Marion, Newton, Searcy, Van Buren and Washington.

Tenth District

Councilor.....	James M. Kolb, Clarksville
Vice Councilor—	
	L. A. Whittaker, Jr., 321 No. 13th, Fort Smith
	Crawford, Franklin, Johnson, Logan, Perry, Pope, Scott, Sebastian and Yell.

APPRECIATION

As the 79th annual gathering of the Arkansas Medical Society draws to a close, after a meeting that was truly delightful and inspiring, we wish to extend our hearty thanks and grateful appreciation to our hosts, the Garland County Medical Society and the individual members thereof; to the citizens of Hot Springs, who have made us feel at home among them; to the management of the Arlington Hotel, who have been, as of old, attentive to our every comfort; to the press, locally, and also at Little Rock, and to many other persons and agencies, who have contributed so generously to our comfort and pleasure. To them we extend our gratitude, and in leaving a community so richly endowed by nature, and marked with innumerable evidences of the energy and loyalty of its citizenship, we hope for them the richest blessings which Providence may bestow upon a deserving people.

MEDICAL CENTER LAY ADVISORY
COMMITTEE

With the designation of Lay Advisory Committee, a group of citizens, under the leadership of Mr. Winthrop Rockefeller has undertaken a task of enormous importance to our State, which is the laying out of a program to achieve the maximum use and benefit of the Medical Center, now being constructed. The successful manage-

ment of this task requires an unusual store of energy, tactfulness and good judgment, all of which qualities are displayed in the highest degree by that committee, to the marked profit of medical education in Arkansas.

Our students will profit from their splendid work, and it will come back to the people enriched by the instruction which our School of Medicine shall bestow upon these future citizens of our State.

To the members of the Lay Advisory Committee, we express our thanks and this token of our continuing esteem; we pledge our support to the committee, and proffer any aid within our power.

DEAN NICHOLSON

The records of the University of Arkansas School of Medicine do not reveal the history of any Dean who has brought to that task an organizational ability quite as high as we have enjoyed for the past five years.

The complex organization which Dr. Hayden Nicholson directs has been marked during his leadership not only by an amazing physical growth and expansion but by an educational program which has been eminently successful in training our youth for a career of medical service.

He has cooperated fully with organized medicine, and has won the respect, esteem and affection of all physicians of our State, all of whom regret exceedingly that he has been called to duty elsewhere.

The Arkansas Medical Society is proud of his record of high achievement and takes pleasure in bestowing upon him its accolade of merit, and we pray for him and his family the richest blessings which a benign Providence may bestow upon a deserving citizen.

PROMPT REGISTRATION AND REPORTING OF BIRTHS AND DEATHS

WHEREAS: Arkansas Act 96 of 1913 authorized the State Board of Health to establish a Bureau of Vital Statistics and provide an adequate system for the prompt and accurate registration of births and deaths, by formulating necessary rules and regulations prescribing the method and form of making such registration, and

WHEREAS, adopted rules and regulations require that within ten days after the date of each birth there shall be filed with the local registrar of the district in which the birth occurred a certificate of such birth, which certificate shall be upon the form adopted by the State Board of Health with a view to procuring a full and accurate report. All certificates, either of birth or death, shall be written legibly in durable black ink, and no certificate shall be held to be complete and correct that does not supply all of the items of information called for therein, or satisfactorily accounted for omissions. The body of any person whose death occurs in this state, or of any child born dead shall not be interred, deposited in a vault or tomb, cremated or otherwise disposed of, or removed from or into any registration district, or be temporarily held pending further disposition more than seventy-two hours after death, unless a permit for burial, removal or other disposition thereof shall have been properly issued by the local registrar. And no such burial or removal permit shall be issued by any registrar until a complete and satisfactory certificate of death has been filed with him, and

WHEREAS, any person, firm or corporation who shall violate any rule, regulation or order of the State Board

of Health relative to recording, reporting or filing information for the Bureau of Vital Statistics, or who shall willfully neglect or refuse to perform any necessary and reasonable duties imposed upon them by said orders, or who shall furnish false information for the purpose of making incorrect records for said bureau, shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined not more than one hundred dollars, or be imprisoned in the county jail not exceeding sixty days, or suffer both fine and imprisonment, in the discretion of the court. The State Registrar (State Health Officer) either personally or by an accredited representative is authorized to investigate cases of irregularity and violations of the law. When deemed necessary, he shall report violations to the Prosecuting Attorney and the Prosecuting Attorney shall take proper steps to enforce the provisions of the Act. The Attorney General is authorized to act as legal advisor of the State Registrar and shall assist in the enforcement of the provisions of this Act, and

WHEREAS, several licensed physicians in the state have, from time to time, violated the provisions of this act, either willfully or unintentionally through numerous instances of delay, incorrect and incomplete information, refusal to complete certificates pending payment of fees; now, therefore,

BE IT RESOLVED, by the House of Delegates of the Arkansas State Medical Society that the Society instruct its membership to promptly comply with the requirements of the Act or suffer the penalties thereby defined,

BE IT FURTHER RESOLVED, that the Secretary of the Society be instructed to mail a copy of this resolution to each member of the Society and that the Editor of the Journal be requested to publish this resolution in an early issue of the Journal.

JONAS SALK

The Annals of American Science do not reveal any figure that can surpass the record achieved in purposeful service by Dr. Jonas Salk, who, while working with voluntary health agencies, gave to humanity a gift of enormous importance in the form of his polio vaccine.

In company with his colleagues from all sections of America, the Arkansas Medical Society is proud of his record of high achievement and takes pleasure in bestowing upon him its accolade of earnest gratitude and highest praise.

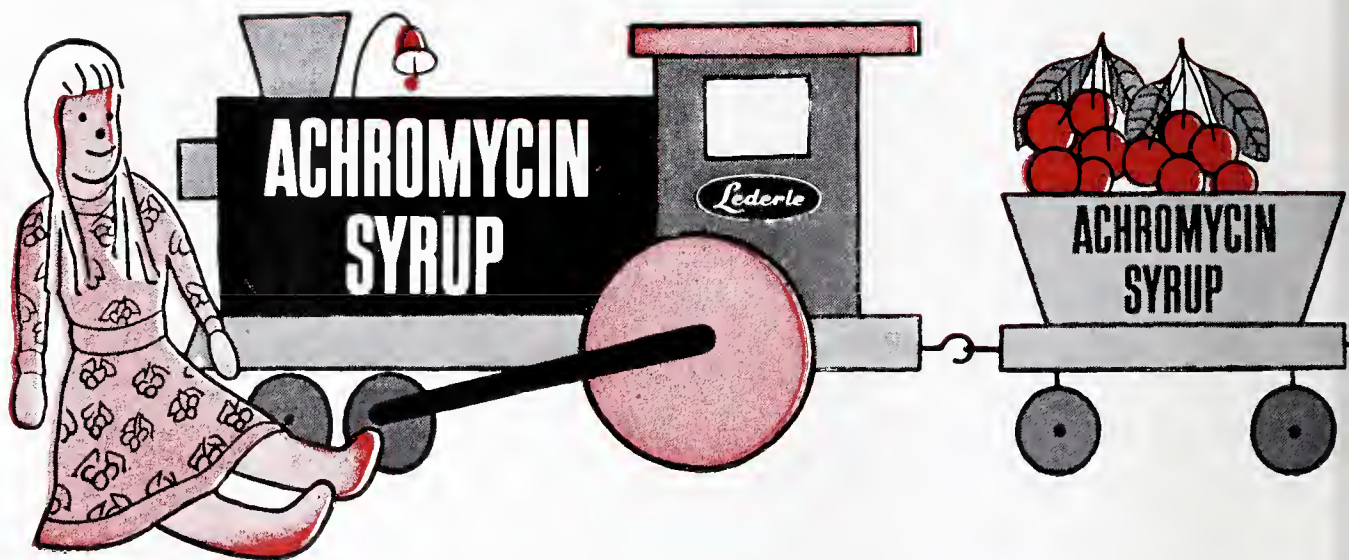
GOVERNMENT INTERVENTION IN MEDICINE

The Arkansas Medical Society, in convention assembled, reaffirms its continued opposition to any and all form of government intervention in the practice of medicine, as in any device tending to detract in any way from the free choice of physician by the patient.

Particularly do we reject any plan which would allow a political appointee without professional qualifications to override the determination of a physician, or the manner in which his decisions shall be made. The physician must be a free agent, responsible only to his God and his patient. Medicine must not be socialized or nationalized or in any way controlled by Government.

The Salk Vaccine was developed by physicians with the aid and assistance of a voluntary health agency. At no point did the Federal Government enter into this discovery. Therefore, we oppose the control and distribution of this product by the Federal Government.

PLEASANT CHERRY FLAVOR!
125 MG. PER 5 CC. TEASPOONFUL! NO REFRIGERATION!
AQUEOUS—NO OIL.



ACHROMYCIN^{*}

HYDROCHLORIDE
TETRACYCLINE HCl Lederle

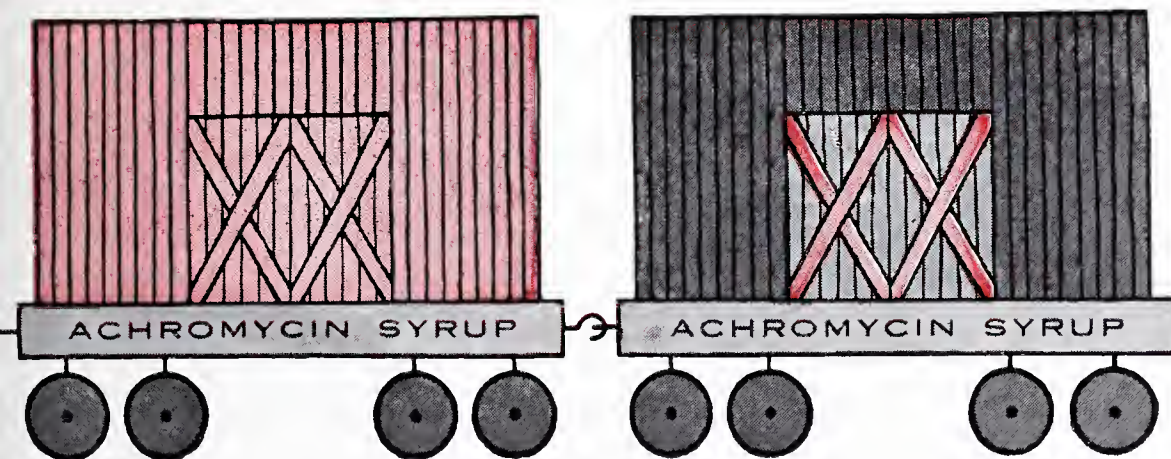
OTHER FORMS OF ACHROMYCIN FOR PEDIATRIC USE:

PEDIATRIC DROPS (Cherry Flavor): 100 mg. per cc. (approx. 5 mg. per drop)

ORAL SUSPENSION (Cherry Flavor): 250 mg. per teaspoonful (5 cc.)

SPERSOIDS* Dispersible Powder (Chocolate Flavor): 50 mg. per rounded teaspoonful (3 Gm.)

READY TO USE! IN 2 OZ. BOTTLES!
NO AFTERTASTE! MISCIBLE WITH WATER, MILK, SODA!



SYRUP

ACHROMYCIN • broad-spectrum • rapid diffusion • prompt control of infection • well tolerated • effective against Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa.

Today's most widely prescribed broad-spectrum antibiotic, tested and accepted by foremost medical authorities, produced and marketed by Lederle.



LEDERLE LABORATORIES DIVISION
AMERICAN Cyanamid COMPANY Pearl River, New York

*REG. U.S. PAT. OFF.

UNITED MINE WORKERS WELFARE AND RETIREMENT FUND

WHEREAS, the American Medical Association is the proper official organization representing medicine in the United States, and

WHEREAS, the American Medical Association is the only organization which can and should speak officially for ALL physicians without regard to their particular field of practice, and

WHEREAS, in the past, that is since 1946, physicians in the State of Arkansas coal producing areas have fully cooperated with the Medical Department of the Welfare and Retirement Fund of the United Mine Workers of America without question as to Specialty Board Certification or membership in the American College of Surgeons, and

WHEREAS, it is now proposed by the Medical Department of the Welfare and Retirement Fund of the United Mine Workers of America that all elective surgery must be sent to medical centers where American Board members of Specialties or Fellows of the American College of Surgery are available, and

WHEREAS, there has been no complaint of record by either the Medical Department of Welfare and Retirement Fund of the United Mine Workers of America or patients receiving treatment from doctors now or having participated in this plan since its inception in 1946, and

WHEREAS, such proposal by the Medical Department of the Welfare Fund of the United Mine Workers of America in effect limit the free choice of physicians by the participating members;

NOW THEREFORE BE IT RESOLVED, that the House of Delegates of the Arkansas Medical Society go on record as opposing such professional qualification requirements by the Medical Department of the Welfare and Retirement Fund of the United Mine Workers of America, and

BE IT FURTHER RESOLVED that the House of Delegates of the Arkansas Medical Society in its regular session this First Day of June, 1955, instructs its delegates to the American Medical Association to introduce and support this, or a similar Resolution, in the House of Delegates of the American Medical Association at its next regular assembly.

A.M.A. CODE OF ETHICS

WHEREAS, Section B, Chapter I, of the Code of Ethics of the American Medical Association, as recently revised, denies to physicians the right to dispense drugs, one of their privileges and duties from time immemorial, and

WHEREAS, this restriction of his rights is not justified and is not in the interest of either the public or the physicians, and

WHEREAS, Section 8 further denies to physicians the right to ownership of a pharmacy if they so desire, one of the constitutional rights of any American citizen, and

WHEREAS, this restriction of his rights is not justified and is not in the interest of either the public or the physicians, and

WHEREAS, Section 8 further denies to physicians the right to a fair and reasonable profit in the providing of remedies to patients, and

WHEREAS, this restriction is contrary to every sound economic principle in the system of free enterprise, and

WHEREAS, these provisions in Section 8 imply on the part of our A.M.A. leadership, a lack of faith in the integrity

of the medical profession as a whole to honestly exercise these rights in the best interests of their patients, and

WHEREAS, this implication is entirely unwarranted and highly repugnant to all of us as honest and conscientious practitioners of medicine.

THEREFORE, LET IT BE RESOLVED that Section 8, Chapter 1, of the Code of Ethics be revised by the House of Delegates of the American Medical Association with the elimination of sentences 1, 2, 3, and 5 in Section 8, and by substituting in their place an affirmation of the above fundamental rights of physicians in the interest of both the public and the medical profession.

HOOVER COMMISSION

WHEREAS, the Arkansas Medical Society has always fostered the concept of better government at a better price for all Americans; and

WHEREAS, the Arkansas Medical Society has consistently endorsed policies established to insure efficient administration of the federal government and to provide maximum savings to the taxpayer, and

WHEREAS, the bipartisan First Hoover Commission, which was unanimously created by Congress in 1947, brought about a number of significant improvements in the administration of our federal government; and

WHEREAS, a bipartisan New Hoover Commission was unanimously created by Congress in 1953 with the major purpose of continuing the search for new ways and means of saving money for the taxpayer, and

WHEREAS, this New Hoover Commission is preparing reports for submission to the Congress with recommendations to provide more orderly and responsible government at less cost; now therefore,

BE IT RESOLVED, by the House of Delegates that we reaffirm our support of such actions in the public interest which are designed to bring about greater efficiency and dollar savings in government operations; and

BE IT RESOLVED that the Arkansas Medical Society urges the President and the Congress to take appropriate steps to carry out the recommendations of the New Hoover Commission, and

BE IT FURTHER RESOLVED that the Arkansas Medical Society alert the members of this organization to the need—on a patriotic, non-political basis—for public understanding, cooperation and action in support of the recommendations of the New Hoover Commission; and

BE IT FURTHER RESOLVED that the members and officials of the Arkansas Medical Society individually and by cooperating with the citizens committee for the Hoover Report—endorse and work toward achieving the vital goal of better, more efficient and less expensive government for all the peoples of our Nation; and

BE IT FURTHER RESOLVED that copies of this resolution be sent appropriate legislative representatives in Washington, D. C., and to the National Headquarters of the Citizens Committee for the Hoover Report, 441 Lexington Avenue, New York 17, New York.

FEDERAL AID TO MEDICAL EDUCATION

WHEREAS, the Supreme Court of the United States has ruled that the government of the United States shall control that which it subsidizes (U. S. 317, 1942, P. 131), and

WHEREAS, it has been the policy of the American Medical Association to oppose federal subsidies to medical education because of the attendant federal control, and

WHEREAS, on May 6, 1955, Representatives of the

American Medical Association, appeared before the Sub-Committee on Health of the Senate Committee on Labor and Public Welfare and offered testimony supporting federal subsidy to medical education (S-1323), and

WHEREAS, the chief burden of their support of S-1323 rested upon their statement that an emergency exists of sufficient gravity to justify acceptance of a single federal grant with its recognized attendant federal control, and

WHEREAS, the American Medical Association's testimony did present background figures proving that American Medical Schools, American Doctors, and American Medicine are the best in the world and that this state of affairs had developed even though the number of medical schools has gradually decreased, their quality has increased, and further, that more doctors are being graduated now than at any previous time in our history, and

WHEREAS, it is obvious that since the quality of medical schools, the training of doctors and the number of graduates is at the highest level ever, these excellent conditions were developed without the dubious assistance of government subsidies, and

WHEREAS, since the federal government receives practically all its financial support from the citizens of the several states, and

WHEREAS, it is the most elementary of mathematical problems to determine that a State can better afford to support its own schools without federal taxation and subsidy than it can after federal taxation and return of a small per cent of the take in subsidies, and

WHEREAS, the federal financial condition is worse than that of any state and the federal government has no money to give to education without further deficit financing, and

WHEREAS, since the Hill-Burton Laws, which provided federal subsidy for construction of hospitals, (also supported by the American Medical Association because they were, originally, a temporary proposition and involved a single grant) now bid fair to become a permanent government subsidy due to the Congressional extension to 1960 and inclusion of additional provisions; the words temporary and single grant offer no protection against perpetuation; now, therefore, be it

RESOLVED, that we, the members of the Arkansas Medical Society, in regular session assembled this first day of

June, 1955, do hereby and herein express as our considered belief that S-1323 represents a further attempt of government to control the practice of medicine in this nation; and, be it further

RESOLVED, that it is our feeling that the American Medical Association knowingly abandoned principle by supporting S-1323, even with reservations, as demonstrated by their statement, "We believe it (federal aid) to be a dangerous device because of the degree of regulation which must necessarily accompany federal funds"; be it further

RESOLVED, that we herein and hereby express our unalterable and unequivocal opposition to federal subsidization of Education, medical or otherwise, temporary or permanent, single or multiple grant; and be it further

RESOLVED, that we, the members of the Arkansas Medical Society, dues paying members of the American Medical Association, do now call upon the House of Delegates of the American Medical Association to retract the testimony which was presented to the Sub-Committee on Health of the Senate Committee on Labor and Public Welfare on May 6, 1955, in support of S-1323; and be it further

RESOLVED, that we strongly recommend that the House of Delegates of the American Medical Association at the 1955 Session adopt resolutions stating an unalterable and unequivocal policy of complete opposition to government subsidization of Education in any degree; and be it further

RESOLVED, that this resolution be spread upon the minutes of this meeting and that copies be sent to:

All Officers of the American Medical Association.

Council on Medical Education and Hospitals of the American Medical Association.

All members of the House of Delegates of the American Medical Association.

Secretary of each state Medical Association.

Officers of the Arkansas Medical Society.

County Society Secretaries of Arkansas.

Executive Secretary of the Association of American Physicians and Surgeons.

Senate Committee on Labor and Public Welfare.

House Interstate and Foreign Commerce Committee.

Arkansas Congressmen and Senators.





MRS. JOHN T. GRAY
JONESBORO

President, Woman's Auxiliary to the
Arkansas Medical Society, 1955-1956

31st Annual Session
WOMAN'S AUXILIARY TO THE
ARKANSAS MEDICAL SOCIETY

Arlington Hotel, Hot Springs

May 30th and 31st, 1955

The Woman's Auxiliary to the Arkansas Medical Society met for the Thirty-first Annual Session in Hot Springs, Arkansas, May 30th and 31st.

Mrs. Hoyt Choate, president, called the executive board meeting to order at 10:00 A.M., Monday, in the East Parlor of the Arlington Hotel, and immediately following the board meeting, Mrs. Frank Adams, president of the Woman's Auxiliary to the Garland County Medical Society, opened the first general session. Mayor Housley and Mrs. C. W. Parkerson, both of Hot Springs, gave welcome messages and Mrs. Kenneth Siler, Siloam Springs, thanked them for the Auxiliary. Mrs. Choate then was introduced and took the chair to preside over the meeting. Several recommendations from the

board were passed without dissenting vote. It was decided that the Councilor to Southern Auxiliary be given authority to vote with the majority at convention in November on the disposition of monies in the Jane Todd Crawford Fund, but that this Auxiliary favors contributing the money to AMEF, ear-marked for Southern Medical Schools.

Mrs. Mason Lawson was presented a certificate by Mrs. Edwin Gray, Little Rock, honoring her with life membership in her county and state auxiliaries. This was done in recognition of her outstanding contribution through the years, and in honor of her elevation to president of the Woman's Auxiliary to the American Medical Association, the first Arkansas woman to achieve such glory.

The body voted to contribute \$100.00 to AMEF in memory of Mrs. B. A. Rhinehart, who was a charter member of the Arkansas Auxiliary and who, until her death in August, 1954, had been a member of the executive board since organization. A very beautiful memorial to Mrs. Rhinehart was read by Mrs. Charles Henry.

It was decided to publish minutes of the Convention provided the price does not exceed \$100.00 and a committee was appointed to investigate.

Guests at the opening session and for the entire convention were Mrs. George Turner, El Paso, Texas, president, Woman's Auxiliary to the American Medical Association; Mrs. Mason Lawson, Little Rock, Arkansas, president-elect Woman's Auxiliary to the American Medical Association; Mrs. Louis Hundley, Pine Bluff, Arkansas, president, Woman's Auxiliary to the Southern Medical Association.

After hearing reports of officers and Committee chairmen, the meeting adjourned for lunch.

Coffee and doughnuts were served by the Garland County Auxiliary before and after the board meeting.

At the luncheon Monday in the Southern Club, Mrs. Louis Hundley, Pine Bluff, President Woman's Auxiliary to the Southern Medical Association, was guest speaker, and since "Doctor's Day" is a Southern project, several doctors were invited guests. Among them, and bringing greetings from the Southern Medical Association, was the president, Dr. R. L. Sanders, Memphis, Tennessee. This was a delightful surprise. Mrs. Hundley spoke on "Life Begins at Forty" and her general theme was friendship.

The second general session was opened at 10:00 A.M., Tuesday, by Mrs. Hoyt Choate, president.

Reports of County presidents were heard and the following slate of officers for 1955-56 read by the Chairman of the Nominating Committee, Mrs. A. A. Little, Texarkana, and elected unanimously:

President—Mrs. John T. Gray, Jonesboro.

President-Elect—Mrs. L. Gardner, Russellville.

First Vice-President—Mrs. J. W. Kennedy, Arkadelphia.

Second Vice-President—Mrs. W. A. Ellis, Helena.

Third Vice-President—Mrs. Paul Gray, Batesville.

Fourth Vice-President—Mrs. Kenneth Siler, Siloam Springs.

Recording Secretary—Mrs. H. King Wade, Jr., Hot Springs.

Publicity Secretary—Mrs. Charles Weber, Magnolia.

Corresponding Secretary—Mrs. Joe Verser, Harrisburg.

Treasurer—Mrs. V. T. Webb, Little Rock.

Historian—Mrs. C. W. Garrison, Little Rock.

Parliamentarian—Mrs. T. D. Brown, Little Rock.

These officers were beautifully installed by Mrs. George Turner, president, Woman's Auxiliary to the American Medical Association.

The Tuesday luncheon was a beautiful affair at the Pines Club on the Little Rock highway. The 146 guests were entertained with a fashion show and music during lunch and Mrs. George Turner, president, Woman's Auxiliary to the American Medical Association, spoke on the aims and projects handed down from National Auxiliary to its 70,000 members. This was her last state auxiliary to visit before the AMA convention where she turned the gavel over to Mrs. Lawson.

The annual session closed with a board meeting immediately following the Tuesday luncheon, with the new president, Mrs. John T. Gray, in the chair.

Mrs. T. Duel Brown,
Recording Secretary.



WHAT'S NEW IN RADIOLOGY*

JOE NORTON, Little Rock

To my mind these WHAT'S NEW discussions are a special and peculiar type of medical presentation. To talk only of new things means at once that you are talking of developments that are as yet unproved. They have not yet stood the test of time. Still, such things are fit for casual discussion, where scientific proof is not required. One might think of this as a bull-session type discussion then—and that is in the old American tradition!

In that spirit I want to briefly touch on some recent developments made in the field of Radiology. I will not attempt to be inclusive nor definitive. My only aim is to acquaint you with some of the interesting developments in my own specialty. And as we consider these new ideas, I think it well for us to recall two quotations which came from MEDICAL MILESTONES by Marriott—"time is the kindest healer, and also the graveyard of many new ideas," and the fact that the "green branches of today are the dead-wood of tomorrow." For a semblance of order, I shall present the discussion under sections:

1. Accessory radiologic supplies and equipment.
2. Roentgen diagnosis and therapy.
3. Radioisotope diagnosis and therapy.

There have been frequent additions to the long list of contrast materials for use in roentgen diagnosis. To my mind, most of those introduced in the past few years seem to have no real advantage over those already in use and proven. However, some of the new preparations are notable. Several new barium preparations are now available, called colloidal mixtures—actually they are not colloidal in the sense the chemist uses that term, but they are finely divided. And some of them are combined with agents which hold them in water suspension longer, which is a decided advantage. I have personally not been too impressed with these new bariums for oral study of the upper gastrointestinal tract, but I have found a new barium compound called BAROTRAST which does allow me a much improved air-contrast colon study. It seems to coat the mucosa better. Even though its use requires a special technique, I think the extra effort well worth while when studying the colon by air-contrast method for demonstration of polyps. A new agent has appeared for intra-

venous administration in the study of the vascular and urologic systems. It is called UROKON.

I personally feel that it allows a denser shadow than the older agents more commonly used, with less side-reaction to the patient. There is still some vein spasm and cramp with its use, but the nausea and vomiting are lessened. A new water-soluble medium called SALPIX has appeared for use in hysterosalpingography, which has the advantage over the older and more commonly used LIPIODOL of being non-antigenic, more quickly absorbed, and still giving just as dense a shadow on film. For oral cholecystography I have used now fairly extensively a new compound called TELEPAQUE. I find it gives an excellent dense shadow usually, with less need for repeat or double-dose techniques, and with less incidence of diarrhea following its ingestion. I use it now in place of PRIODAX. Also I have found that in oral cholecystography the use of one of the newer gallbladder evacuants, as CHOLESTIM, is a much more satisfactory fatty meal than just telling the patient to go get some cream or eggs or other fatty foods. With these newer evacuants, which are quickly and easily prepared and are palatable, the gallbladder contracts quicker and more completely, so that the after-fat meal films can be obtained in 30-45 minutes usually. And with these evacuants, if there is a desire to study the biliary ducts, then quite often they can be demonstrated in films made 10, 20, or 30 minutes after giving the stimulant. Also, if desired, one can go on to the barium meal study of the upper intestinal tract, for the quantity of stimulant given orally is small and does not interfere with study or motility of the upper intestinal tract. A new compound called CHOLEGRAFIN is now available for the study of the post-cholecystectomy patient who continues to have pain, and who is suspected of having biliary duct stones. It is also useful in the patient who cannot take the oral medium for gallbladder study because of nausea or vomiting or diarrhea, and in patients for whom a further check on non-visualization from oral medium is desired. This material is given intravenously, and, when successful, will visualize the common bile duct and some of the hepatic biliary radicles. If the gallbladder is in place, it also is visualized in later films. Often duct stones can be picked up in this manner. If there is severe hepatic damage, the material will be excreted by the kidneys in sufficient density to allow a urogram. Indeed, if a urogram is shown on the films rather than the bil-

* Presented at the Seventy-ninth Annual Session, Arkansas Medical Society, Hot Springs, Arkansas, May 30, 1955.

iary system, that is good evidence of severe hepatic disease and damage. One other contrast medium should be mentioned, and that is DIONOSIL for use in bronchography. It comes in aqueous and oily solutions. My own experience with it has been limited, but it has been used extensively in many centers, including our own Arkansas Medical School. The oily solution of DIONOSIL seems to have the ability to map the bronchial tree as well as the more commonly used LIPIODOL, with the advantage that DIONOSIL is almost completely absorbed and removed from the lung within just a few days of administration. As we all know the LIPIODOL often stays in the lung for years, obscuring to some degree the lung fields when further roentgen study is desired.

The aqueous solution of DIONOSIL is irritating, but the oily solution is well tolerated and easy to use. Of course, all of these contrast media which contain iodine should be used only after appropriate sensitivity tests to iodine have been satisfactorily performed. Ingenious radiologic equipment is continually being developed for both diagnostic and therapeutic use. It appears that new leaded glass gowns may replace someday the old heavy lead rubber aprons. The lead glass gown is more attractive, easier to use, and gives more protection, but is also much more expensive now. Several companies are now offering protective film badge services at very low cost, which allows any X-ray office to check on its safety levels easily. The American College of Radiology has brought out a new book entitled *PLANNING GUIDE FOR RADIOLOGIC INSTALLATIONS*, telling exactly how to plan a department of radiology in an institution or a private office. This is an excellent book, and should be in the hands of any who are considering the addition of X-ray equipment to their offices. Equipment for body section study (called laminogram, tomogram, or planigram) and for seriographic study of the cardiovascular system is being further perfected. Also cineradiography is coming into more general use in some larger centers, allowing motion picture roentgen studies. This is a great help especially in studying joints and the digestive tract.

One of the outstanding developments in equipment is the electronic fluoroscopic image amplifier apparatus, which allows a fluoroscopic image to be obtained that is at least 200 times brighter than the image obtained with ordinary fluoroscopic equipment. The image is so bright that it compares favorably with the film study, and can be studied in the lighted room, without the need for dark-adaption. Only the high cost of this equipment keeps it from more general use now.

Radiotherapeutic equipment has also been improved. We now have X-ray therapy machines operating on millions of volts, instead of the now commonly used 200-250 thousand volt range. Machines have been developed which allow a rotation of the patient, or of the tube about the patient, during treatment, so that a deeper tumor dose of energy can be given, with less skin reaction. A development that has captured the popular imagination is the radioisotope bomb—the cobalt bomb or cesium bomb machines. These isotope therapy machines are now available in many sizes, and are a great advance in radiotherapy equipment. These and the supervoltage X-ray machines are massive equipment, quite expensive, and, because of the energies of radiation delivered, pose many problems of protection in their placement. Particle accelerator machines, as the betatron, are also being improved, using electron or neutron beams. The biological effect of these beams is similar to that of X-ray. So far these particle beams are only being used experimentally, and their place in therapy is not yet determined.

There have been many interesting developments in roentgen diagnosis. The fine work of Poppel and others have stimulated all to closer and more detailed study of the pancreas, so that radiologists are now more confident in study of that organ than previously. Seriographic studies of the cardiovascular system continue to add to our knowledge of cardiovascular abnormalities and anomalies, and also to correct many a false impression gained from plain film and fluoroscopic studies, especially as regards the anatomy of the cardiovascular system. Translumbal aortography is now almost routine in many centers, allowing excellent visualization of the abdominal aortic and renal circulation. Splenoportal venography, obtained by direct injection of opaque medium into the spleen percutaneously, is now done freely in many places, and allows excellent study of the portal system, the liver, and may show liver tumors and even esophageal varices very well.

In these vascular injection studies, we in the United States are far behind our colleagues in the Scandinavian, English and European areas. Somehow experimental work of this type seems to catch on more quickly in those countries. As you know, it is now a common procedure in many areas to do liver biopsy. The radiologists now also needle the liver percutaneously, and on finding a biliary duct, can obtain an excellent film study of the hepatic biliary system and common duct by simply injecting therein an opaque material and filming.

Two simple techniques have aided in routine barium studies of the gastrointestinal tract.

One is the use of a new position called the "squat" position, made by filming directly through the patient's back and pelvis in a dorsocaudal direction as the patient sits on the table over the film in a squatting position. This allows an excellent study of the posterior portions of the rectosigmoid area—and also of the posterior surface of the bladder in an opaque cystogram, and of the pelvic inlet in pelvimetry. The other technique, which is useful in hunting for small elusive hiatal herniations of stomach, is to have the patient bend forward at the waist and try to touch his toes, while being observed in an erect lateral position fluoroscopically. This will often show a hiatal hernia when all other methods used have failed. Also more frequent use of the lateral and oblique and erect positions in filming the gastrointestinal and urologic tracts is giving much more information in these studies.

We have long used the anteroposterior and lateral projections in the studies of extremities and chest, but have only lately realized their worth in gastrointestinal and urologic X-ray studies. An additional technique of tremendous help in urologic X-ray study is the taking of a delayed urogram film at a 1 or 2 or 4-hour interval, when the regular 15 or 20-minute excretory film shows a poor or non-visualization of a collecting system. Often on this delay film, which is just another KUB, made in the usual manner, with the patient maintained during the interval on a nothing-by-mouth regimen, the collecting system which failed to show on the earlier films will be visualized as a large hydronephrotic system, with perhaps the dilated ureter pointing to an area of obstruction, due perhaps to a non-opaque stricture or non-opaque stone. Presacral air injection studies are other additions to urologic X-ray study. In the past the study of the kidney and other retroperitoneal organs by perirenal air insufflation was considered a dangerous procedure, and never enjoyed wide use. Now we know that air injected into the loose areolar tissues of the presacral space will find its way to the retroperitoneal area and will often well outline those organs there. Often combinations of presacral air, excretory urography, body section radiography, and translumbar aortography are done, allowing excellent study of kidneys, adrenals and other retroperitoneal masses. This can all be done in the usual X-ray department of a hospital. With more thoracic surgery being done now, it is necessary to study more closely chest tumors and cavities and other such conditions. For this reason more use

is being made now of body-section equipment, which allows one to select any plane in the body and film it particularly, blurring out those body planes above and below the selected plane, obtaining thereby a good cross-sectional study of the selected area. With this technique, often cavities can be shown which were obscured by thick pleura or fluid or tumor in conventional studies. This equipment is also of great use in studying the larynx and in studying certain joints, as the temporomandibular joints. The advances of thoracic surgery are also causing us all to look more thoroughly and closely at those confusing solitary pulmonary coin lesions found occasionally on routine chest films. Many studies of these small non-calcified lesions, which we would all like to call just non-calcified scars, have shown that 15-70% of them are lung malignancies, the percentage differences being due to age of patient primarily. The older the patient, the more likely is the coin lesion a malignancy. The study of the herniated nucleus pulposus—the "slipped disc" of the lay—has always been a big problem in our country. In some of the European areas a new method for study of these discs has been introduced, and is claimed by many of their top radiologists and orthopedists as far superior to the routine myelogram, such as is more commonly done here. This is called diskography, and consists of direct injection of an opaque material through the annulus into the nucleus pulposus, and then showing by films the herniation of the nucleus containing the opaque material.

In our country we do not yet so freely stick long needles so deeply into the backs of our patients. One of our most frequent studies is the oral cholecystogram, which now enjoys an accuracy of about 95% when well done. One drawback of the newer media, previously mentioned, is that the dense shadows obtained may obscure small stones. For this reason, it may be necessary to use additional techniques in studying particularly the patient who seems to have a satisfactory gallbladder shadow, but who also has a colic history which cannot be ignored. Such patients should have added to the routine positions used, films made in erect, lateral, oblique and decubitus positions. The right lateral decubitus position, where the film is made in a posteroanterior projection while the patient lies on the right side, is very good for displacing overlapping confusing gas shadows from the gallbladder—in this position the gas shadows seem to rise away from the area.

One new wrinkle in roentgen study of the chest, being experimentally used now, is the use of su-

pervoltage equipment—in the range of 1,000 kilovolts in place of the conventional 100-125 kilovolts—to make chest film exposures. The studies obtained seem to allow a better visualization in the mediastinal areas without burning out too badly the lung field detail.

When one thinks of irradiation therapy, one usually thinks of its use in cancer treatment. But many studies made during the past year have reaffirmed the value of properly prescribed irradiation treatment in many benign conditions, such as calcified peritendonitis or bursitis, furuncles (especially those about the nose and face), certain varied dermatologic conditions, thyroiditis, Marie-Strumpell type of rheumatoid arthritis, empiric relief of pain in muscles, ligaments and joints, as an adjunct in therapy of pancreatitis by decreasing secretion, in treatment of post-operative parotitis by the same action, and in the treatment of non-malignant menopausal bleeding. Other conditions could certainly be listed. Still, most irradiation therapy is cancer therapy, and much improvement and progress has been made here also. There is some promise in the experimental studies of the use of certain chemicals given orally or by injection to so affect the cancer cell as to enhance the effect of ionizing radiations. This is experimental now, but is certainly intriguing. The use of the multiple port techniques and the rotational equipment has been referred to, allowing a better tumor dosage with less skin and superficial reaction. The use of supervoltage X-ray therapy equipment and radioisotope bomb equipment certainly is a forward step in cancer therapy, for they allow a much better tumor dose to be obtained with less skin reaction. With this equipment it would appear that one could better treat recurrent cancer through old surgical or irradiation scar, and better treat those patients whose tumors are partially hidden by bony mass or whose tumors are so located that single port techniques are necessary. At these energy levels the absorption of the energy by bone is about the same as by soft tissue, and overlapping bone is no hindrance to the depth dose as it is with conventional therapy equipment. However, we must all remember that these are new techniques—long term results are not yet available. And they are deadly energy which must be very carefully used. Not all tumors are suitable for such energy treatment. Not all tumors need such treatment. The equipment is massive and expensive and can only be properly used where there is a physicist in daily attendance to check on the output of energy, the isodose curves of the energy, and the protective devices. Already it has been found

that, though the skin reactions are less troublesome, still areas of deep tissue necrosis in the tumor bed are causing trouble to the patient. I like to remember that no irradiation or surgical procedure yet devised is the final answer to the cancer problem. The cancer still must be localized to respond to our treatments by these methods.

Once the cancer has spread to other parts of the body, we can only palliate, no matter how much we cut or how hard we irradiate. The answer to the cancer problem will probably come in some other field, but, in the meantime, while awaiting that answer, I feel much progress has been made in surgical and irradiation care of these unfortunate patients. In all methods of irradiation treatment we are now aware of the need for more precise methods of dosimetry and technique, and also for more careful analysis of treatment results. To assess the true value of the modality of treatment used in cancer therapy, we must always remember to compare the best with the best—not the best surgical treatment with the worst irradiation treatment, or vice-versa—but the best in surgical treatment with the best in irradiation treatment. Then we will know where we stand as regards those two excellent methods of treatment of cancer. Actually there has been such a variation in surgical and irradiation techniques used in cancer treatment that one can almost prove any point he wishes from some of the available literature, when he is trying to show the superiority of one method over the other. Always compare the best with the best. One important discovery is that many of the severe radiation reactions can be relieved by the careful and proper use of cortisone. Such reactions of skin and deeper tissues are necessary evils in the present irradiation techniques used if cancer is to be cured. THORAZINE has been found helpful in patients who become nauseated while under irradiation treatment. DEXAMYL is of aid in keeping up the spirits of those who become depressed during the long hard course of therapy. The local use of toilet lanolin or boric acid 5% in aquaphor on the skin seems to lessen the skin reactions from heavy irradiation.

Urine alkalinization usually relieves the dysuria of radiation cystitis well, and the use of starch retention enemas often relieves the discomfort of radiation proctitis, such as often occurs during the long courses of irradiation treatment for cancer of the cervix.

The study of the radioisotopes continues at a rapid pace. We now have about 300 known isotopes, but we have found medical uses for rela-

tively few, including Cobalt 60, Iodine 131, Gold 198, Strontium 90, Cesium 137, and Phosphorus 32. The isotopes have been used quite successfully in the study of the physiology and pathological physiology of our bodies.

Iodine 131 has been of some aid in localizing certain intracranial tumors of nervous tissue, but is only 40-50% successful, and is used only to supplement already proven means of localizing such tumors, as encephalography. Perhaps the most outstanding clinical use of the radioisotopes is the use of Iodine 131 in the study of thyroid function.

This is so easily done and is so reliable that it seems to be replacing the older BMR determinations. The dosages of the radioactive isotopes used are so small as to not constitute a patient hazard. The measurement of uptake by the thyroid is very accurate. It is essential that there be no iodine intake for some time prior to the test, and that thyroid medication be stopped about 2 weeks prior to the study. Often an error in the test is explained by finding that the patient had a LIPIODOL bronchogram or a PANTOPAQUE myelogram in the past, with still residual iodine in the body. But with these and other small limitations, the test is much easier to do and much more reliable than the BMR study of thyroid function. Incidentally, fine articles appeared in the JAMA, Volume 154, February 6, 1954, one by Pierce on page 495, and one by Quimby on page 499, concerning the setting-up of a radioisotope laboratory in a general hospital. These articles should be consulted by anyone faced with that problem.

So far as radioisotope therapy is concerned, remarkable progress has been made, but we have yet no isotope that can be ingested or given intravenously that will answer the cancer problem. The use of the isotope bombs has already been referred to. Isotopes, as Cobalt 60 and Gold 198, are now obtainable in many forms, so that they can be used interstitially, intracavitarily, and in plaques ingeniously, allowing cheaper and better irradiation than was obtained with radium and radon. The availability and lower cost of these isotopes will certainly mean that there will be much more use of interstitial needles and seeds in the future. This should markedly improve irradiation results in many cancers, as for example, those in the mouth.

There has been much work with Iodine 131 in the hyperthyroid patient with a diffuse toxic

goiter, and the results obtained here seem comparable with those of surgery. For this reason radioactive iodine is an excellent choice for treatment of patients with diffuse toxic goiter, with recurrent goiter after partial surgical removal, and in patients who refuse surgery or in whom surgery is contraindicated. The only disadvantage with irradiation of the gland is that it does take some time to do. There is no proof that cancer change will result.

Iodine 131 should not be used in treatment of the nodular goiter, for only by surgical removal of the tissue and pathological study can one be sure there is no malignancy in that type goiter. Iodine 131 is of no real value in the treatment of cancer of the thyroid. Since the radioactive iodine is so well taken up by the thyroid and depresses thyroid activity, it has been used quite successfully by Jaffe and others in the care of the euthyroid patient who develops intractable congestive failure or angina, which fails to respond to the ordinary other methods of therapy. It is safe and satisfactory to make such euthyroid patients mildly hypothyroid by giving radioactive iodine in suitable dosage, thereby lowering the total body metabolism to the limits of the failing heart. Any undesirable excess hypothyroidism can be promptly relieved by the use of thyroid extract. Jaffe's work in this respect was reported in the JAMA, February 28, 1953. Phosphorus 32 continues to be the treatment of choice for polycythemia vera. It is no better than conventional roentgen therapy in the leukemias, but is an aid at times. Gold 198 has found some use in treatment of prostatic cancer by direct injection of the material into the prostate, but the results are not too good. Nor has the injection of Gold 198 into the pelvic tissues of females aided much in cancer of the cervix, even though some of the gold does find its way into the pelvic lymphatics. Gold 198 has also been used by direct injection into malignant effusions of the abdomen or chest, and in 40-50% of the cases, it does seem to lessen the reaccumulation of fluid, though it does not cure the patient. It is worth a palliative trial in such cases when distension by fluid is causing symptoms.

This has been a rambling presentation. An effort has been made to cite many varied interesting developments in Radiology that have occurred recently, and which are either being used now, or which seem to hold promise for future use, with more study and perfection.

MANAGEMENT OF PREGNANCY IN ESSENTIAL HYPERTENSION*

JAMES HENRY FERGUSON, Miami, Florida†

Essential hypertension, or chronic hypertensive disease as we obstetricians seem to prefer to call it, exists in women who have a persistent hypertension (140/90 or over) before the 24th week of pregnancy. We have to suspect it in women who exhibit hypertension in more than one pregnancy and it certainly exists in women who have high blood pressure between pregnancies.

The hazards to which the hypertensive woman exposes herself determine our objectives in the management of her pregnancy. The prime objective is to produce a live baby that will survive. The fetal salvage in the presence of hypertension is distinctly less than in normal women. We have found at the Charity Hospital in New Orleans that the fetus fares worse in the presence of chronic hypertensive disease than it does with the acute form of toxemia, preeclampsia-eclampsia.¹ The second objective of our management is to prevent the chronic hypertensive syndrome from worsening. By worsening I mean a further elevation of the blood pressure or the appearance of albuminuria.

I base my recommendations of the management of pregnancy in essential hypertension on our extensive experience on the Tulane Service at the Charity Hospital. In a representative year, 1950, we had 347 women who delivered and who had essential hypertension. Thus in my almost 8 years of experience at Tulane, about 2,500 women with this syndrome had babies. In this year 1950 we had a fetal survival record that was considerably better than in generally being reported.

We strive for our objectives by meticulous antepartum care and in the last trimester of pregnancy by the exercise of obstetric judgment in deciding how and when the pregnancy shall end. The patients should be seen early in pregnancy and seen frequently. We like to see most of our patients every week, especially in the last half of pregnancy. We see them in a special toxemia clinic where careful, unhurried attention can be given at each visit. A rigid control of weight gain is maintained principally by emphasis on curtailment of salt. Diuretics are used frequently in the last weeks of gestation to combat excessive rates of weight gain; usually this gain is due to abnormal retention of water. The various new one-a-day

tablets have been tried, including oral mercurials, but have not been demonstrated to be more efficacious than 12 tablets of ammonium chloride a day. Epsom salts by mouth are used much less frequently than formerly because we have been disappointed in the amount of water that has been excreted by the bowel. The importance of a complete, well balanced diet is stressed. The component of the diet on which we place greatest emphasis is protein and we advise a generous supply of it.

As in all people with essential hypertension, sedation and rest are important foundations of therapy; the amount of sedation and rest must be suited to the severity of the hypertension. Phenobarbital is the most frequently prescribed sedative. A program of ten hours in bed at night and one hour rest after the noon meal would seem to be a minimal desideratum for mild hypertension.

We have not used hypotensor drugs in obtaining our rather good results. These new medicines may eventually prove to be important parts of the management of essential hypertension in pregnancy. As yet, possibly due to their newness, it has not been demonstrated that they produce a better fetal outcome or reduce the chances of albuminuria.

A decision of greatest importance is the selection of the time to hospitalize the patient if it becomes desirable to enter the hospital before the onset of labor. We hospitalize at once all patients who develop a superimposition of preeclampsia upon the essential hypertension. This superimposition of preeclampsia we recognize by the appearance of albuminuria or a substantial increase in the blood pressure. If admission to the hospital is impossible, care that approximates it is indicated. It may be because of our vigorous management of women with this superimposed preeclampsia that we have a better fetal survival rate than in the women with well controlled hypertension; this is the opposite of the usual experience. Some patients are hospitalized for the purpose of induction of labor. A few are admitted because of excessive weight gain and not a few enter the hospital for a thorough evaluation of their cardio-renal status.

A judicious shortening of pregnancy is often indicated. This can be accomplished, in ascending order of radicalism, by digital loosening of the membranes ("stripping"), outright induction of la-

† From the Department of Obstetrics and Gynecology, School of Medicine, Tulane University.

* Presented at the Seventy-ninth Annual Session, Arkansas Medical Society, Hot Springs, Arkansas, May 30, 1955.

bor, or Cesarean section. The method and the timing of termination of pregnancy are determined by the severity of the blood pressure, persistence of albuminuria, size of the fetus, previous obstetric history, and condition of the cervix.

We do not hesitate to strip the membranes in the clinic without any special preparation; we think this loosening of the membranes will hasten the appearance of a more favorable cervix and in some instances will produce labor. For a more overt induction of labor our favorite is a carefully administered dilute pitocin infusion. On rare occasions it will cause the blood pressure to ascend and we then discontinue it. A surer method of induction is rupture of the bag of waters and we like to have the head engaged and the cervix unquestionably favorable ("ripe") before we do it.

Although we have the feeling that at some point in each hypertensive pregnancy the fetus has a better chance outside the uterus than inside, we do not have a slide rule by which to decide when and how pregnancy should be terminated. Each case must be settled on its individual merits by the application of obstetric judgment. Obstetric judgment cannot be put into print but let me cite three broad types of cases that we see fairly regularly and explain how they are handled: (1) is a multipara with a good fetal survival history and a hypertension that is not more than moderate. If the fetus is of an acceptable size the membranes will be stripped thoroughly at each weekly visit in the last month of pregnancy. If she fails to go into labor then, close to term she will be admitted for induction; (2) a multipara with no children or too few children to show for the number of her pregnancies will have an induction of labor as soon as the cervix is ripe and the fetus is large enough to be worth the chance. Lacking a favorable cervix, or if the woman is in an older age group, we would consider Cesarean section; (3) the woman with essential hypertension who becomes worse is admitted to the hospital. After she improves and if the cervix is ripe, the labor is induced. If she does not improve in a reasonable length of time and if the fetus is large enough, she has a Cesarean section, or an induction, whichever the favorableness of the cervix dictates.

I. Ferguson, J. H., and Miller, H. K. Toxemia of Pregnancy at the Charity Hospital in New Orleans. In press, *Surgery, Gynecology and Obstetrics*, September, 1955.

"The penalty that the people pay for not being interested in politics is to be governed by people worse than themselves."—Plato.

FIFTY-YEAR CLUB

Arkansas Medical Society

DR. J. H. McCURRY, Secretary

June 2nd, 1955.

The Fifty-Year Club of the Arkansas Medical Society was royally entertained by the generosity of the Parent Society Tuesday morning, May 31st at Cafe No. 2, Arlington Hotel, and went on record as being highly pleased and thankful for the honor given and the splendid cooperation extended by the officers of State Society, and especially by Mr. Paul Schaefer.

We desire to extend thanks to Dr. H. King Wade for his fine talk and to Dr. E. H. Watson of Ann Arbor, Michigan for the interesting pictures and fine talk before the Club.

After a nice breakfast the following officers were elected—Dr. William H. Mock of Prairie Grove was named President for 1956. Dr. W. E. Hamil of Pocahontas Vice-President and myself remain Secretary.

Sincerely,

J. H. McCurry.

NEW JERSEY DOCTORS CONTRIBUTE TO AMEF

A treasury grant of \$25,000 from the Medical Society of New Jersey will be awarded to the American Medical Education Foundation this year to help support our nation's medical schools. The contribution was presented to the Foundation during the AMA's 104th Annual Meeting June 6-10 at Atlantic City. F. M. Clarke, the state's AMEF chairman, notified the Foundation office that the grant was voted by the New Jersey House of Delegates at its annual convention held in April at Trenton.

Total contributions to the AMEF so far in 1955 exceed \$303,685 from 4,225 donors. This figure includes also a grant of \$100,000 from the AMA.

NEW FILM ON RHEUMATIC FEVER

A new health education film, "Stop Rheumatic Fever," has just been added to the AMA's Motion Picture Library. The film was developed to impress upon parents, teachers and the public the fact that rheumatic fever can be prevented by early diagnosis and treatment of streptococcal infections. This 12-minute black and white sound film, employing symbolic animation to emphasize the point, is suitable for parent groups, service clubs, public health nurses and high school students.

— ★ Editorial ★ —

It comes as a shock to hear a report from Director John Herron that there are physicians in our state who are refusing to obey the law which requires that all birth and death certificates be signed at the earliest practical time. There is hardly any excuse for the delay in filling out these proper papers within 3 or 4 days, and certainly no valid reason, unless the physician is dead.

It is forbidding to think that some of these signatures are being held up to enforce the payment of fees. It is, moreover, unreasonable for a physician to be so negligent that a court action is threatened to force him to do his professional and civic duty.

We can assist our State Board of Health in its various functions, by being cooperative in the matters of required records, and Arkansas physicians must, and will, give this cooperation.

Funds for the American Heart Association are being asked for in a nationwide campaign initiated this last month. Physicians of Arkansas will respond to the best of their ability. Some of the leaders of the drive have petitioned Congress to provide for a part of their program, but it is to be hoped that the generosity of the American public will furnish the funds in a voluntary way rather than ask our Congress for enforced charity. Physicians are long ensconced on a battle to provide for our institutions through gifts rather than make them wards of a government, and subservient to the shrunken dollar that comes from Washington.

GUEST EDITORIAL

MR. PETER DIESCH, Helena

A bill was introduced in the House of Representatives at the last term, to create the Arkansas Medical University, which received much thought by your Legislative committee, and members of the profession from whom we sought counsel. Simply stated, the bill would sever our medical school from the University, and create a new board of trustees for its control.

Apprehending that a similar bill will make its appearance at a future session, our membership should be apprised of it, so that your committee could be guided by the opinion of the membership. The bill would change the name of our medical school, as it now exists, to that of Arkansas Medical University.

Such a change would undoubtedly lead to confusion of identity. The school of medicine of the University of Arkansas was established in 1879, and it has maintained its identity through all the years to this date. That name has been built up to have meaning and prestige through its title and its accomplishments. The name of a great business or industrial corporation is protected by law. Trade marks are recognized through names and symbols. No one is allowed to encroach upon them, for there is value in the name and accomplishment. Likewise an institution or group treasures its name.

Many alumni and others have given their full measure of devotion to the medical school under its present name. Prestige earned by merit, and long years of achievement are woven into the fabric of its being. It has won the respect and esteem of our people. Its mission and its accomplishments are dear to our hearts. In large measure it has fulfilled the dreams of its pioneer founders and of the generation of doctors who have fostered and nurtured it.

Under the inspiration of this Society our medical school was formed, and with the stimulus so provided it has grown and developed into an institution of enormous importance. The basic work done in our University medical school in chemistry, bacteriology and medical science and a score of interlocking subjects have quietly poured their knowledge into the swelling stream which has borne us forward in progress. No single life in our time in this State is untouched by the work which it has done and is now being done there.

Significant expansion of our medical school's program of research and teaching will soon be achieved by means of the generosity of our Legislature. Should this fine tradition of education be molested by a change of name?

PROGRESS WITH THE GROWTH HORMONE (An Editorial)

ALFRED KAHN, JR., Little Rock

Metabolic investigation is one of the most active fields of medical research. The past decade has seen the clinical application of much basic research on the adrenal cortex hormones. Because the basic research in most medical fields leads eventually to clinically valuable information,

it is most important for the clinician to follow developments in basic science research.

Currently, much interest is manifest in the Pituitary Growth Hormone. Weil has reviewed this recently, (*Archives of Internal Medicine*, Vol. 95, p. 739, May 1955). Weil has examined the effects of GH (growth hormone) on protein, carbohydrate, and fat metabolism. Some of his information is summarized here. Growth through GH promotes nitrogen retention. This has been proved by analyzing the carcasses of animals treated with GH and comparing them to controls. Growth can be maintained indefinitely by continued treatment and it stimulates all tissues. Its effect is greater if amino-acids, the building blocks for protein, are readily available. GH causes its effect on protein by two principal actions: reduced rate of destruction of amino-acids and by increased protein manufacture from amino-acids. It is of great interest that this protein synthesis is greatly diminished in the absence of insulin; an increased insulin output follows treatment with GH; if the pancreas is removed injections of insulin will increase the effect of GH. One might reasonably speculate here, what are we doing for the thin patient in whom we are trying to induce weight gain with insulin?

GH is capable of intensifying diabetes directly without this effect being mediated through another gland. GH stimulates the Islets of Langerhans to produce insulin, and a single injection decreases the blood sugar. Continued stimulation induces degeneration of Islets and leads to elevated blood sugar and diabetes mellitus. Removal of the pituitary gland in some animals prevents the usual signs of diabetes developing after injection of GH, although it does induce a great resistance to insulin. Excision of part of the pancreas will enhance the effects of GH by removing some of the Islet tissue. There is another interesting effect of GH on carbohydrate; GH helps maintain the body's carbohydrate stores by reducing the glycose requirement of the tissues.

GH reduces the body's stores of fat by their mobilization and oxidation. Weil considers this effect on fat the primary function of GH. He suggests the following chain of events after giving GH. First the complex fat molecule is mobilized, and then broken down into simple two carbon chains. Then one of four things may happen. Some of the chains are oxidized for energy. Another portion is used to form amino-acids, and these are then converted to protein. A third portion is transformed into ketone bodies in the liver; these ketone bodies are carried via the blood over the entire body and are burned pref-

erentially thus saving carbohydrate. Lastly some of the two carbon fragments form complex chemicals as cholesterol, etc.

What is the implication of this basic clinical research? It is this, almost all therapeutics modifies the body's metabolism. In surgery and during the post-operative period marked metabolic changes occur; equally dramatic changes occur in the treatment of medical diseases. The alert clinician has a better understanding of his patient's disorder and treatment if he understands the underlying chemical and physiological changes. This is a practical, not theoretical, point because it results in lowered morbidity and mortality.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.

The Part II Examinations of the American Board of Obstetrics and Gynecology were held May 12 through 20 at the Edgewater Beach Hotel in Chicago, Illinois. Three hundred eight-seven candidates were examined.

After twenty-five years of continuous service, Walter T. Dannreuther was succeeded as President of the Board by F. Bayard Carter. Dr. Dannreuther will continue with the Board as a member of the Executive Committee.

Applications for certification for the 1956 Part I Examinations are now being accepted. Candidates are urged to make such application before October 1, 1955. Write—

Robert L. Faulkner, Sec.
2105 Adelbert Road, Cleveland 6, Ohio

BOSTON CLINICAL MEETING American Medical Association November 29 - December 2, 1955

All persons who desire a place on the lecture program at the Boston Clinical Meeting of the American Medical Association are urged to communicate immediately with the Chairman of the Program Committee—Theodore L. Badger, M.D., c/o Massachusetts Medical Society, 22 The Fenway, Boston 15.

Applications for space in the Scientific Exhibit are now available and will be sent on request. Exhibits will supplement the lectures as far as possible, and should portray subjects of a broad general interest. Requests for application should be sent to the Secretary, Council on Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois.

PUBLIC Physician Personal Patient

RELATIONS

The Arkansas State Medical Assistants Society held its First Annual Convention at the Arlington Hotel in Hot Springs May 28-29, 1955.

Activities began with registration on Saturday afternoon, followed by a cocktail hour and buffet supper that evening. John McC. Smith, Little Rock, entertained the group by his "magic tricks."

On Sunday morning, Mrs. Mason G. Lawson, President-Elect of the Woman's Auxiliary to the American Medical Association, spoke on "The Significance and Value of the Medical Assistant"; Alfred R. Sugg, a past president of the Oklahoma State Medical Association, discussed "How to Win Patients and Influence Doctors," and Henry B. Gotten of Memphis, author of "Physicians' Office Attendants Manual," talked on "Public Relations at the Front Desk."

At the luncheon meeting, Mrs. W. Alvin Pennington of Hot Springs spoke on "The Magic of Enthusiasm," followed by a talk on "Arthritis" by Euclid M. Smith, of Hot Springs, a past president of the Arkansas Medical Society.

At the annual business meeting on Sunday afternoon, Miss Eva Antonio of Hot Springs was elected president-elect, and will be installed as president at the convention in 1956.

And Clipping Bits Here and There

Arkansas

TRAVELING

CLIPPED AND SNIPPED FROM THE HOOVER COMMISSION MEDICAL REPORT

The report estimates that the Federal government "has undertaken specific responsibility for all or part of the medical care of about 30 million" citizens; 4 million (mostly servicemen) entitled to complete care and 3.5 million veterans entitled to complete care for SC disabilities; over 20 million eligible on a facilities-available basis, including 2.9 million dependents of military personnel and 17.5 million veterans eligible for hospitalization on their statement of inability to pay; and 2.5 million Federal employees eligible for limited on-the-job health services.

The Federal government employs about 10 per cent of all active physicians, 9 per cent of active dentists and 6 per cent of the active graduate nurses. In 1953, Federal hospitals had about one-sixth of the nation's GM&S beds, one-twelfth of the mental hospital beds and over one-ninth of the TB beds; of 19.9 million admissions to hospitals that year, 1.5 million (over 7.5 per cent) were to Federal hospitals.

The Commission found 66 administrative units with health functions in 26 Federal departments or agencies, but no clear definition of Federal responsibility for medical care (particularly for Public Health Service and VA beneficiaries) and no over-all supervision, which has resulted in faulty coordination of services and supplies and in excess facilities and personnel. One table in the report shows sufficient empty beds in Navy hospitals to care for all Air Force patients and sufficient empty Army beds to care for all patients of both the other services.

The report proposes closing at least 12 hospitals, with possible shutdowns of more than 30 others, which could be sold as "surplus" for civilian use. The Commission says that better coordination of military health facilities, elimination of PHS care for merchant seamen and general reappraisal of Federal medicine will allow this cut-down with no diminution of essential health services to the armed forces or others properly entitled to Federal care.

Doctors in Uniform

According to the government's Health Resources Advisory Committee, in a report issued this February, there are about three times as many physicians in the armed forces as are needed to provide essential medical care. These physicians, say the report, spend only 10 to 12 per cent of their time in caring for dependents of servicemen. The medical profession is eager to provide the best of care for the armed forces, but when the government itself says that two-thirds of the physicians in uniform are not really needed, the AMA opinion that much of the "shortage" of medical personnel is artificial seems to be well substantiated.

FROM THE SECRETARY'S LETTER

American Medical Association

For the Youngsters—Medical Mystery Shows!

A wholesome and instructive medical who-dunit transcription series will be available after June 15 from the AMA's Bureau of Health Education for airing over local radio stations. Entitled, "Dr. Tim, Detective," this series relates some of the

novel experiences which the doctor and his teenage pals—Sandy and Jill—have solving mysteries related to health.

Written and produced by the Rocky Mountain Radio Council under the supervision of the Bureau, this series is particularly suitable for those radio listening hours directed to the small fry. Medical societies sponsoring "Dr. Tim" transcriptions might wish to inform the local P.T.A. of the hour the programs will be aired.

Subjects included in the 13-program series: diabetes, rabies, hearing, dope peddling, hookworm, appendicitis, asthma and allergies, anesthesia, nursing care, blood and fractions, rheumatic heart disease, Rocky Mountain Spotted Fever, and patent medicines.

AMA MEETING

The Atlantic City meeting of the A.M.A., June 6-11, gave us the following:

Dwight H. Murray, new president-elect.

Next meeting: Chicago, June, '56.

Interim meeting: Boston, December, '55.

Distinguished Service Award to Donald C. Balfour, Rochester, Minnesota, for outstanding achievement in medical education and research.

Refused to accept a majority report that Osteopathy was a significant part of medicine, and adopted a minority report that Osteopathy was a "cult," and that "if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept,' with proper deletion of said 'osteopathic concept' from catalogs of their colleges; and may approach the Trustees of the American Medical Association with a request for further discussion of the relations of Osteopathy and Medicine, then the said Trustees shall appoint another special committee for such discussion."

Had this to say on physicians owning drugstores, dispensing, handling of eyeglasses, etc.:

"Your committee recommends that no one of these (above) resolutions be adopted as submitted but does recommend deletion of Section 8, Chapter I of the Principles of Medical Ethics which now reads:

" 'Ownership of Drugstores and Dispensing of Drugs and Appliances by Physicians

" 'Sec. 8. It is unethical for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable. This inadequacy must be confirmed by his component medical society. The same principle applies

to physicians who dispense drugs or appliances. In both instances, the practice is unethical if secrecy and coercion are employed or if financial interest is placed above the quality of medical care. On the other hand, sometimes it may be advisable and even necessary for physicians to provide certain appliances or remedies without profit which patients cannot procure from other sources.'

"Your committee recommends that the following be substituted in lieu thereof:

" 'Dispensing of Drugs and Appliances By Physicians

" 'Sec. 8. It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient.'"

In reporting to the House the chairman of the Reference Committee explained that in the opinion of the Committee the Code of Ethics should be stated in broad principles rather than attempt to interpret principles in detail. In recommending the change in Section 8 the Committee emphasized that this section should be interpreted in line with Chapter I, Section 6, which reads: "The ethical physician, engaged in the practice of medicine, limits the sources of his income received from professional activities to service rendered the patient"

This change was adopted. Physicians "may now own stock in drugstores or dispense as long as there is no exploitation of the patient—no kick back, or unethical procedure in which the patient is kept in the dark."

Made no changes in Internship Approval Programs.

Acknowledged the widespread dissatisfaction of the function of the Joint Commission on Accreditation of Hospitals and instructed an independent committee to survey and report at the December meeting.

Joined in the reaction of scientific bodies against government direction, and interference with the progress of polio immunization.



TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

THE ELIMINATION OF TUBERCULOSIS FROM THE MIDWESTERN STATES IN THE NEXT FIFTY YEARS

By DAVID T. SMITH, M.D., *Diseases of the Chest*, December, 1954

The National Tuberculosis Association was founded fifty years ago. At that time the public believed that tuberculosis was inherited and that to plan its control was a utopian dream. The death rate in the death registration area was 200 per 100,000, with the major part of the deaths in infants and young adults. In the northeastern states nearly 100 per cent of the population had a positive tuberculin test by the age of 20. There were only a few thousand beds for patients with tuberculosis in the entire United States. The X-ray technique for finding tuberculosis was undeveloped and case-finding clinics as we know them today were non-existent. There were only two encouraging factors: deaths from tuberculosis had been almost twice as frequent 50 years before and a new organization had dedicated itself to the elimination of this dreadful disease.

It is probable that the death rate from tuberculosis in the midwest was never as high as in the northeast. There the standard of living was higher and the opportunity for infection was less than in the more crowded northeastern states.

By 1920 in the midwest there were enough sanatorium beds to isolate and treat most of the known active cases. However, many cases were missed until the X-ray method had been perfected and larger segments of the population X-rayed.

There are no accepted criteria for determining when tuberculosis is under control in an area. It is suggested that tuberculosis be considered under control when the death rate is five or less per 100,000 of the population and five per cent or less of the school population have positive tuberculin tests. Wisconsin is approaching this goal of control; the death rate for 1952 being 6.5 and tuberculin tests in school children in 1950 five per cent positive. The other midwestern states are approaching the status of control.

When tuberculosis is under control then we can begin to plan for its eradication. To consider the crude overall death rate alone is misleading. The

age and sex groups which harbor the remaining reservoirs of infection must be known.

The most striking feature of the 1950 figures is the steady rise in the Wisconsin death rate for men from a low of 0.1 at the age of 12 to 61.2 at the age of 85. The chief reservoir of tuberculous infection is now in males over 40 and females over 60 years of age. This is the seed bed from which the next generation will be infected unless all of the active cases are detected, isolated, and treated.

Almost as many new cases are being found now as were being found when the death rate was four times as high. Indeed, one may conclude that the present death rate is an artificial condition brought about by early diagnosis, better medical and surgical treatment, and is not the result of a natural decrease in either the prevalence or severity of tuberculosis. If treatment should continue to improve we might find ourselves in an anomalous situation in which there were no deaths but with a continuing heavy load of active cases in our hospitals. The greatest defect in our present methods of control is the lack of specific information in regard to the number, age and sex distribution of individuals who have been infected.

The percentage of positive tuberculin reactors is an indirect measure of the amount of undetected open tuberculosis in the community. A positive tuberculin test pinpoints the individuals in the group in which new active cases will develop. A recent conversion from a negative to a positive tuberculin reaction means that there is an active case among the converter's associates. There is a rough correlation between the percentage of the population with positive tuberculin reactions and the number of clinical cases and the number of deaths from tuberculosis.

In 1950 in Wisconsin there was an average rate of 1.7 deaths per 100,000 for the age group under 20 and 26 per 100,000 for the ages of 50 to 80. The school children in Wisconsin have five per

cent positive tuberculin reactors and it is assumed that the older groups have a tuberculin rate of 50 per cent.

The corresponding data from Minnesota for the year 1952 shows a death rate of 0.7 per 100,000 in the age group under twenty years of age and in the age group of 50 years and older a rate of 19.4 per 100,000. The tuberculin rate in school children in Minnesota is now about three per cent in contrast to 50 per cent for adults over 50.

Larger samples of tuberculin tests especially among adults of different ages are needed. When the data are available it may be possible to predict from the percentage of positive tuberculin reactors the expected annual number of new cases and of deaths from tuberculosis.

As the program for the elimination of tuberculosis progresses, intensive X-raying of certain segments of the population will probably replace general mass X-ray surveys. Repeated annual X-rays on males over 40 and females over 60 would yield many active cases of tuberculosis, of carcinoma of the lung and of heart disease. Ideally each individual with a positive tuberculin reaction should be X-rayed every year.

The routine X-raying of general hospital admissions has yielded from two to ten times as many active cases of tuberculosis as mass X-ray surveys in the same areas. Before long it will be more economical to carry out admission tuberculin tests on all patients under 40 years of age followed by an X-ray of all positive reactors and continue to X-ray individuals over 40. The same method of tuberculin testing and X-raying could be carried out by private practitioners of medicine.

The key to the elimination of tuberculosis is the tuberculin test which tells us which individuals have living virulent tubercle bacilli in their bodies. An annual X-ray of tuberculin reactors should detect the disease early enough to cure the patient before the infection of others. Routine annual X-rays without tuberculin tests, should be continued for the heavily infected group of individuals who are now 40 years of age or over.

Some may be shocked by the suggestion that 50 years would be required to eliminate tuberculosis from the midwestern states. This is a conservative estimate based upon assumptions such as: no disturbance in our present high standard of living, no catastrophic war or social upheaval, an increase in case-finding programs and a maintenance of the present sanatorium system with its expensive medical and surgical treatment.

The long incubation period for the development of clinical tuberculosis explains the long time re-

quired. To this must be added the prolonged persistence of tubercle bacilli in the bodies of those who have been treated and are apparently well. All physicians can recall instances where a person has "cured" in his twenties and has remained well until he relapsed in his seventies. Even more disturbing is the young child who is infected and does not develop clinical tuberculosis until old age.

Leprosy is the only other human disease which has a comparable long incubation period and a comparable long period of infectivity. Leprosy was eliminated from Europe between 1300 and 1600 A.D. by an intensive program of isolation. It required 300 years to eliminate leprosy from Western Europe. It did not disappear spontaneously and persists even today in tropical countries.

Obituary

ROBERT LOUNDS HOPKINS, 74, of Maitland, Fla., a former physician and surgeon of DeQueen, died April 30. Born March 1, 1881, he was graduated from the school of medicine at Vanderbilt University and did post-graduate work in Chicago. He served with the armed forces during World War I.

He retired in December, 1945, and moved to his citrus farm near Maitland, Fla., but continued his frequent visits to DeQueen.

Funeral services were held May 2. Interment was in Green's Chapel cemetery. Survivors include his wife, Mrs. Vida Ferrel Hopkins, two brothers, and several nieces and nephews.

ROBERT LEE BRYANT, 54, who had practiced medicine in Arkadelphia for 20 years, died at his home in that city on May 29, of a heart attack. He was a graduate of the University of Arkansas School of Medicine and was an active member of the Clark County Medical Society and of the Arkansas Medical Society. He was a member of the Methodist Church, and served in the Armed Forces during World War II.

He is survived by his wife, his mother, and a son, of the home, and by two brothers and six sisters.

The funeral was held May 31, at Murry's Funeral Church.

ELWOOD BAKER, 83, passed away May 30. He was a physician and surgeon at Dermott since 1902.

He graduated from the University of Tennessee School of Medicine in 1901. He did graduate study at Poly Clinic Medical School at New York City in 1907 and has been local and dispensary surgeon for the Missouri Pacific Lines since coming to Dermott with the exception of two years spent during World War I in the Army Medical Service.

He was a member of the Chicot County, Southeast, and State Medical Societies, the Dermott Rotary Club, and the American Legion. He was a Presbyterian.

Survivors include two brothers and two sisters.

Funeral services were held at the Dermott Presbyterian Church. Burial was in the Dermott cemetery.

SPARKS FROM THE SECRETARY

This year's convention was one of the best. Registration was excellent, the program was one of the best ever devised, especially the scientific program. I heard several doctors say that the scientific program was the best rounded that they had ever attended. I think this speaks very well for Alfred Kahn, Jr., and his committee.

The past year has been a very swell year for Bill Brooksher; his sense of the proper thing to say and do at the appropriate time is always correct and has been a wonderful year for him. Things have been running very smoothly because of his ability. I had the cockeyed idea at Hot Springs of presenting to him, in some public meeting, such as the House of Delegates, with a catfish in a frozen cake of ice, but I got to thinking about his powers of retaliation and figured he might stick it in the back of my car after the ice was well melted and I'd be stuck with a stinking mess for awhile, so I didn't work it out.

I suppose everybody heard that the House of Delegates passed a resolution that the wonderful program was in part due to the very excellent arrangements of King Wade, Jr., Councilor from that District and that an appreciation of his excellent work was expressed and a copy of this resolution be sent to his Father, King Wade, Sr. Everybody got a big kick out of this, especially King Wade, Sr., as he was present when the resolution was passed!

One of the outstanding events, of this meeting was the Conference on Cancer, sponsored by the Arkansas Division of the American Cancer Society, on Sunday. Julius Hellums, the Chairman of the Board of Directors of the Arkansas Division, presided. The program consisted of the following: Cancer seen by the General Practitioner—C. A. Archer, Jr., the Chairman of the Arkansas Cancer Coordinating Committee: Results in Surgical Treatment of Cancer of the Cervix—Joseph H. Pratt, Surgical Department Head Mayo Clinic: The Conquest of Colonic Cancer—Fred J. Hodges, Professor and Chairman, Department of Radiology, University of Michigan:

The development of Cobalt 60 as a radiation substitute—Isodore Meacham, Professor and Head of Department of Radiology, University of Arkansas School of Medicine: The Arkansas Program by Bill Stapleton, Executive Director of the Arkansas Division of the American Cancer Society. The Cancer: Frontiers of Research—Charles S. Cameron, Medical and Scientific Director of the American Cancer Society, New York City. A question and answer period was also held. This program was outstanding; it was geared to the general practitioner and to the informed

layman. There was standing room only and it was a marked success from every point of view. The Cancer Society certainly plans to have another one because it was such a whopper of a success.

The Woman's Auxiliary meeting was remarkably good. One person, who has attended many Auxiliary meetings, and who is not in the least bit afraid of criticizing them, said that this was the most interesting and "to the point" meeting that she had ever attended. The program committee of the Woman's Auxiliary is certainly to be complimented. Of course, one of the high points of the Woman's Auxiliary was the fact that their own Mona Lawson, who is soon to be installed as the President of the American Medical Association Auxiliary was present, as was the President of the Southern Medical Association Auxiliary, Mrs. Jean Hundley. My home town must come in for a little bit of credit, because Mrs. Dorothy Gray made such an outstanding presentation of her committee report. She certainly is a charming person and I understand gave her report in an expert and entertaining manner.

I hope that you will read the resolution regarding our objection to federal aid to education, medical or otherwise, which probably is somewhere in this current issue, or will be in the next issue. This was taken somewhat word for word from a resolution which we received from Tarrant County, Texas, (Fort Worth). It is a masterpiece of wording and sounds as though our unreconstructed rebel president-elect, who is also the editor of this Journal, has written it in person. I think you will really enjoy reading it.

J. J. MONFORT.

Proceedings of Societies

Twenty-five state urologists organized a Urologic Section at the recent session of the Arkansas Medical Society in Hot Springs, and plan to hold meetings twice a year. One will be held at the Annual Session of the Medical Society, and speakers from the Urologic Section will be available for the general meeting.

G. W. Reagan, Little Rock, was elected its first president; Sam Jameson, El Dorado, vice president; and Ralph Downs, Fort Smith, secretary-treasurer.

The Ninth Councilor District Society met at Cave Springs, June 16, on the occasion of the annual picnic of the Washington and Benton County Medical Societies. More than 100 physicians and their wives and guests were present. Martin Eisele, Hot Springs, and David Levine, Tulsa, furnished the program. A fish-fry completed the evening.

Ben Saltzman, Mountain Home; L. H. McDaniel, Tyronza; Charles Henry, Little Rock; W. H. Pruitt, Camden, and James Wortham, Little Rock, made significant contributions to the Fifth Arkansas Rural Health Conference held June 28 and 29.

Union County Medical Society presented a "South Arkansas Seminar" on Trauma on July 17.

Personal and News Items

Warren Murry, who will be discharged from the Air Force in August, has received his certificate of initiation into the American Board of Surgery. He is expected to open offices in Texarkana.

Mrs. John T. Gray, recently installed as President of the Woman's Auxiliary to the Arkansas Medical Society, attended the Woman's Auxiliary to the American Medical Association meeting held in Atlantic City, June 6-10, 1955.

W. F. Shepherd has returned from the Army following a two-years' tour of duty, and reopened his offices in Jonesboro.

David Dawson, Newport, closed his office in May and entered the Army Service School in Ft. Sam Houston, Texas.

Four Ft. Smith physicians have opened private offices in a new 22-room Clinic Building on Lexington Avenue. They are John Ben Stewart, Ralph G. Kramer, Robert J. Thompson, and Jon Thompson.

W. K. Bell, Benton, left July 1st to begin a year's residency in Pathology at Gorgas Hospital in the Canal Zone.

W. R. Brooksher, Ft. Smith, the immediate past-president of A.M.S., addressed the Medical Service Society of America in Hot Springs, May 22.

Stewart M. Wilson, Rogers, was elected a Fellow in the American College of Physicians in Philadelphia in April.

George G. Graham, a native of Newport, is opening offices in Little Rock. He was Chief Surgeon at U. S. Naval Airbase at Millington, Tenn., during his tour with the Armed Services.

Kenneth L. Roark, Conway, closed his office June 1st and reported to Ft. Sam Houston, Texas, for permanent duty with the Army.

Robert M. Kelly has moved from Lonoke to Sheridan where he will do a general practice at Sheridan Clinic. He will occupy the same offices held by his uncle, the late O. R. Kelly.

Mrs. Robert Fee Hyatt, Monticello, was honored recently as Arkansas "Mother of the Year" at the May 1-3 meeting in New York. She is the mother of two physician sons, Robert C. and Lewis Hyatt.

The following Arkansas physicians were registered at the AMA meeting in Atlantic City, N. J., June 6-10: George C. Burton, El Dorado; John A. Hall, Clinton; Alfred A. Berger, Helena; Anthony M. Grasse, Calico Rock; John T. Gray, Jonesboro; M. H. Harris, Newport; Davis W. Goldstein, Ft. Smith; James M. Kolb, Clarksville; J. H. McCurry, Cash; L. H. McDaniel, Tyronza; and Eva F. Dodge, H. M. Hawkins, Joseph P. Hickey, A. W. Strauss, James L. Smith, K. W. Cosgrove, Edwin F. Gray, Oscar Gray, Jr., Mason G. Lawson, all of Little Rock.

BOOK REVIEWS

A Textbook of Physiology: Edited by John F. Fulton, M.D., Sterling Professor of the History of Medicine, Yale University School of Medicine, with the collaboration of Donald H. Barron, William D. Blake, John R. Brobeck, George R. Cowgill, Paul F. Fenton, Thomas R. Forbes, Samuel Gelfan, David I. Hitchcock; Hebbel E. Hoff, David P. C. Lloyd, Theodore C. Ruch, Jane A. Russell. Edition: Seventeenth. Pp. 1,275. Illustrated. 1955. \$13.50. W. B. Saunders Company, Philadelphia.

There is considerable tendency, in recent years, to tie in some clinical material with the preclinical studies of our medical students. This serves two purposes. It holds the interest of the student, ties him to the clinical aspect, It also makes a textbook a real reference book for the clinician.

This tendency is excellently portrayed in Fulton's Physiology as compared with an old edition, though it is a literary descendant of that volume. New sections have been added, and new importance is given to various body systems. In this text the Physiology of the nervous system, and its collaterals occupy a large percentage of space. The Physiology of the glands of internal secretion, hormones, etc., occupy a greatly expanded space, and are given minute attention.

The other systems—circulation, digestion, respiration, etc., are rewritten and presented with the latest of theory and proven hypotheses. They are all present and completely presented.

Any clinician can find information on the Physiology of the patient that comes to him in this text. It is long, necessarily, and goes into considerable detail, but it is readable, clear and factual. Its primary use is in the school room, but it can fill a vacancy in any practicing physician's library, and will fill a source of background unequalled in the exhaustive study of a Physiological process.

..... The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

AUGUST, 1955

No. 3

ABNORMAL HUMAN HEMOGLOBINS*

A. S. KOENIG, Fort Smith

Until 1949 only two types of human hemoglobins were identified. These consisted of hemoglobin A or adult hemoglobin and hemoglobin F or fetal hemoglobin. When these hemoglobins are subjected to electrophoretic fractionation in the tiselius apparatus they cannot be distinguished from each other, in as much as the mobility of hemoglobin F is identical with that of hemoglobin A. Erythrocytes containing hemoglobin F were thought to disappear completely from the circulation within a few months after birth. However, as will be shown, syndromes have been described in which there is persistence of hemoglobin F. It can be separated only from the adult form by virtue of the property of F hemoglobin to resist alkali denaturation. In studies of numerous blood specimens from normal individuals it has been shown that hemoglobin F concentrations up to 2% may persist to adult life. Levels above 2%, however, are significantly abnormal in character.

In 1949 Pauling¹ and his associates, studying hemoglobin from patients with sickle cell anemia, were able to demonstrate the existence of an atypical hemoglobin which has a greater mobility than adult or fetal hemoglobin and which they designated as sickle cell hemoglobin or hemoglobin S. They also demonstrated that the essential differences lay in the protein or globin fraction of the hemoglobin molecule, this difference being responsible for the greater mobility of S hemoglobin in the electrophoresis apparatus. They also showed that when S hemoglobin is subjected to a reduced oxygen tension, concentrates of the hemoglobin become very viscus and form tactoids which are long, spindle or boat-shaped particles which are quite rigid, resulting in birefringence of the cell and distortion of the cell membrane to accommodate the rigid structure within the cell membrane. This phenomenon is thought to be responsible for the sickling which is observed under the microscope.

Sickle cell anemia and sickle cell trait had been poorly understood until the time of Pauling's¹ publication and as a result of his work and additional studies done by Neel² in the same year the genetic mechanisms involved were established. Neel² showed that sickle cell anemia represented the homozygous condition for sickling and sickle cell trait represented the heterozygous condition. In 1951 Kaplan³ and his associates, studying individuals showing sickle traits, described still another atypical hemoglobin which occurred both in combination with adult hemoglobin and S hemoglobin and in the electrophoretic apparatus had a greater mobility than either the adult or S type of hemoglobin. They designated this as hemoglobin III. It has subsequently become known as hemoglobin C. They showed that C hemoglobin when in combination with S hemoglobin produces a clinical syndrome which has now become well recognized but formerly was described as an atypical type of sickle cell anemia. Kaplan³ and his group also demonstrated that erythrocytes from individuals with hemoglobin C trait when transfused into normal persons had a very decreased survival time, the cells all being destroyed quite rapidly. The determination of survival time of erythrocytes in this condition, as well as in subsequent hemoglobin disorders, has become one of the methods of investigation.

In 1952 Sylvestroni and Bianco⁵ described another syndrome which occurred in Italy having some of the characteristics of both sickle cell anemia and Mediterranean anemia. On the basis of studies of eleven families they found that the presence of the sickle trait in one parent and of microcythemia or Mediterranean anemia in the other parent results in a hematologic disease in some of the off-spring which they termed microdrepanocytic disease. Hematologic and genetic studies on these patients indicated the simultaneous presence of both sickle cell and microcythemic genes.

*Presented at the Seventy-ninth Annual Session of the Arkansas Medical Society at Hot Springs, June 1, 1955.

The method of electrophoresis in the tiselius apparatus is expensive and time consuming and the method does not lend itself to large scale studies. A mass survey of the population to determine the distribution of these atypical hemoglobins was not possible until 1953 when it was found that the method of paper chromatography could be applied to the study of hemoglobin mobility. Smith and Conley⁴ at Johns-Hopkins studied the blood from 1,000 individuals consisting of random cases selected in the out-patient department of that hospital. The group included 500 whites and 500 Negroes. As a result of their electrophoretic studies the following distributions were determined: There were 5 cases or 1% of Negroes who had sickle cell anemia or were homozygous for sickle cell disease. Thirty-six cases or 7.2% of the Negroes possessed sickle cell trait or were heterozygous for sickle cell disease. One patient or 0.2% possessed a combination of C and S hemoglobin. Nine patients or 1.8% were heterozygous for hemoglobin C, it being in combination with the adult hemoglobin. There were no cases of homozygous C individuals. None of the 500 white persons studied possessed either hemoglobin S or hemoglobin C.

A third atypical form of hemoglobin, designated hemoglobin D, has recently been described. It has a mobility in the electrophoresis apparatus identical to hemoglobin S. Reduced forms do not form tactoids. Cells containing hemoglobin D do not sickle. It is distinguished from hemoglobin S by the fact that it behaves in the electrophoresis apparatus like hemoglobin S but under reduced oxygen tension the cells do not sickle.

As a result of the investigations which have been mentioned, it is now possible to classify many of the hematologic disorders associated with hemoglobins C and S into definite clinical syndromes. Those disorders with hemoglobin S or sickle cell disease are as follows: 1. Sickle cell trait. 2. Sickle cell anemia. 3. C variant of sickle cell disease. 4. Microdrepanocytic disease. 5. D variant disease.

Sickle Cell Trait: This condition, as previously mentioned, has been shown to exist in from 8 to 10% of Negroes and it represents the heterozygous form of sickle cell disease as described by Neel³. Electrophoretic studies of the hemoglobin in these patients show the concentration of a hemoglobin to be 50 to 80%, S hemoglobin 20 to 50%. Clinically, there is no anemia: the red blood cells when transfused into normal individuals will survive for the normal length of time, 120 days. This is of significance because these per-

sons may be satisfactorily used for blood donors. Sickling is not observed on dried blood films from these patients. However, when fresh preparations of blood are subjected to low oxygen tensions the sickling phenomenon may be produced in vitro. Target cells are either absent or extremely rare.

Sickle cell anemia possesses S hemoglobin with a fetal hemoglobin component ranging from 2 to 24%. These patients have a normochromic normocytic anemia and the usual clinical syndrome which is familiar to you all consisting of weakness, jaundice, low grade fever, chronic ulcers of the legs, abdominal pain and the sickling phenomenon is readily observed in both dried blood films and in fresh preparations. Target cells are also numerous and the red cell survival time of these patients is extremely shortened.

The C variant of sickle cell disease consists of either a combination of C and S hemoglobin or C plus S plus F. The F ranges in the neighborhood of 2 to 3%. These patients represent individuals who are off-spring of one parent who possesses the C trait, the other parent possessing the S trait. Anemia is either absent or very mild. There may be a compensated hemolytic process present, as evidenced by increases in serum bilirubin and reticulocyte levels. Hemolytic crises do not occur in these patients. The sickling phenomenon is not observed in dried blood films, but it can be produced in fresh preparations in vitro subjected to reduced oxygen tension. Target cells are numerous in the blood smears. The red blood cell survival time is extremely shortened. In two of the cases studied there were survival times of 12 and 18 days respectively. Therefore, these patients would not be suitable to be utilized as blood donors.

In microdrepanocytic disease concentrations of F hemoglobin may be present up to 17%. The sickling hemoglobin is greater than 50% of the total content. In these cases the genes for sickling and thalassemia are located on different chromosomes and they are inherited independently of each other but are simultaneously present in the affected red blood cells. These patients, who were described by Sylvestroni and Bianco⁵, apparently were white individuals or whites with a mixture of Negro blood residing in Italy. It is possible, therefore, that syndromes containing microcythemic and S hemoglobin factors may be detected among some of the white people of Mediterranean extraction who have immigrated to this country. These patients clinically have a

symptom complex similar to sickle cell anemia but the red blood cells are found to be microcytic. This phenomenon is not observed in pure sickle cell disease. Anisocytosis and poikilocytosis in these patients is much more severe than in sickle cell disease. Sickling may occasionally be seen on dried blood films but is rarely produced on wet preparations under reduced oxygen tension. The red blood cell survival time of these patients is greatly shortened and target cells are numerous in the peripheral blood smears.

Disorders with hemoglobin C consist of: 1. Hemoglobin C trait. 2. Pure hemoglobin C disease. 3. C variant of sickle cell disease, which has just been described. 4. C variant of thalassemia.

The hemoglobin C trait consists of adult and C hemoglobin representing a heterozygous condition, according to Neel's hypothesis, and it occurs in approximately 2% of American Negroes. Anemia in these patients is completely absent, there being no clinical symptomatology. The red blood cell survival time is normal and these patients, therefore, are suitable to be utilized as blood donors, but target cells are numerous in blood smears. They occur in from 75 to 100% of the red cells. This trait may be suspected in a Negro patient who shows an extremely high percentage of target cells and who has no evidence of a clinical hematological disorder.

In pure hemoglobin C disease the C hemoglobin constitutes 100% of the hemoglobin component of the red cells. It is an extremely rare condition. Singer⁴ has described only two cases. In these patients anemia is absent, being fully compensated as evidenced by elevation of the serum bilirubin and reticulocyte levels of 8 to 10%. Splenomegaly is usually present. The red blood cell survival time is greatly shortened and target cells are very numerous, comprising approximately 80% of the red cells.

Hemoglobin C thalassemia disease is another extremely rare condition and only two cases have been described in one Negro family by Singer⁴. The distribution of the hemoglobin component in each of the two patients is shown in the diagram. These patients both displayed a hypochromic microcytic type of anemia. They had splenomegaly and leg ulcers. Target cells were numerous in the peripheral blood. The red blood cell survival time was not studied in these cases, but it probably would be shortened.

You have observed the occurrence of hemoglobin F in some of the syndromes described. It

occurs in 50 to 90% of newborn infants and is gradually replaced by the adult type of hemoglobin. The presence of F hemoglobin may help in distinguishing the sickle cell trait from sickle cell disease in off-spring of sickle cell parents, because if the F hemoglobin is replaced by the adult from the individual will probably not have sickle cell disease, but will be only an individual with a sickle cell trait and not be subjected to the usual hemolytic crises and clinical symptomatology encountered in homozygous sickle cell anemia. Interestingly enough fetal hemoglobin in levels over 2% are occasionally found in leukemia, pernicious anemia, aplastic anemia, multiple myeloma and metastatic carcinoma. When the primary disease is undergoing regression and under treatment the fetal hemoglobin usually disappears from the blood.

Conclusion

The description of the abnormal hemoglobins, the syndromes with which they are associated and the significance of the various types serve to clarify our understanding of many previously obscure hematological disorders. The most outstanding of the syndromes described, that being the C variant of sickle cell disease has become of particular significance in recent years since the abolition of segregation in the armed forces. Several cases have been reported in Negro airmen, apparently normal individuals who experienced splenic infarction and hemolytic crises during high altitude flying. As additional studies are conducted in the future there will probably be many more cases of the C variant of sickle cell anemia described.

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4. Smith, E. W., and Conley, C. L.: Filter Paper Electrophoresis of Human Hemoglobins, With Special Reference to Incidence and Clinical Significance of Hemoglobin C, Bull. Johns Hopkins Hospital 93:94, 1953.
5. Silvestroni, E., and Bianco, I.: Genetic Aspects of Sickle Cell Anemia and Microcytic Anemia, Blood 7:429, 1952.
6. Singer, Karl: Clinical Significance of Abnormal Hemoglobins. Yearbook of Pathology, Yearbook Publishers, Chicago, 382:394, 1954.

HIATUS HERNIA AND PEPTIC ESOPHAGITIS*

ALFRED KAHN, JR.

Introduction

The medical profession has recently showed a renewed interest in the subject of the diaphragmatic hernia. Bockus¹ credits Ambroise Pare' with giving the first description in the modern literature. From the same source is taken the following outline of the different types of diaphragmatic hernias—90% of which are false and contain no peritoneal sac:

"I. Anterior—Hernias located on either side of the attachment of the diaphragm to the sternum. They may occur through Larrey's space or the Foramen of Morgagne.

"II. Costal—This form of hernia may or may not present a sac and appears at areas not related to the fusion lines of those parts combining to form the diaphragm.

"III. Posterior—This type results usually from lack of closing of the pleuroperitoneal canals and originates in the lumbar region at or near the foramen of Bochdalek.

"IV. Esophageal—This is due to a failure of normal approximation of the two crura. These hernias are frequently true sacs.

"V. Rarely hernias may occur at the hiatus of the sympathetic nerve in the crura of the diaphragm."

This discussion will be limited to (A) hiatus hernias which may be associated with congenitally short esophagus or short esophagus due to scarring, or (B) a normal length of the esophagus. In the former case, a portion of the stomach remains in the chest. In the latter, the stomach may slide back and forth from the abdominal to the thoracic cavity.

Clinical Features

Hiatus hernias are not rare. They vary in frequency in different series; from 3% to 12% of all G.-I. series will demonstrate hiatal hernias.² In my private practice about 5% of the G.-I. series show hiatus hernias. Whether or not the hernia is the source of the G.-I. complaint is at times a moot point. In general, however, a G.-I. series would not have been performed if the patient were not symptomatic; if the hernia is the only lesion found and if the symptoms fit the accepted clinical picture of this disease, then the hernia should be considered to have a pathogenetic role.

The most widely taught symptoms of this disease are dyspepsia and burning epigastric pain which are relieved by standing and increased by lying down. The symptoms tend to appear in people in middle life and occur in women much oftener than men. Most of these patients tend to be overweight.

The symptom complexes produced by hiatus hernias may be exceedingly variable, and like syphilis it is a great imitator. For example, listen to this case.

Case No. 1. Mr. D., a 64-year-old, white married man, was first seen in July, 1950, with a chief complaint of abdominal pain of five years' duration. The pain was described as being in the epigastrium and knot-like in character. It usually occurred as the patient ate his meals. It would have a rather sudden onset, lasting 15 minutes to one hour and would slowly disappear. When the attack struck, the patient felt, in addition, a sense of being unable to swallow any more food. He would usually become so uncomfortable that he had to leave the table. Recently, eating was invariably followed by vomiting of food and mucus within 20 minutes of the ingestion of food. The attacks were infrequent and widely spaced at onset, but they had progressed to the point of occurring three times daily. Very recently the abdomen had felt sore on pressure in the epigastrium. The week before the patient was seen he passed a large tarry stool. He denied jaundice, diarrhoea, or hematemesis. His only previous gastro-intestinal complaint was a questionable history of a duodenal ulcer over 30 years ago. His appendix had been removed. Generally, the patient felt very poorly. He had given up his job. He complained of such severe weakness that he did not want to leave his home to be examined. He was apathetic and depressed.

Family, social and habit histories were non-contributory. Past history disclosed malaria as a youth.

Systemic review offered no helpful data. He had a mild visual and hearing defect, dentures and a nasal allergy.

Physical Examination: Weight 169 pounds height 5' 8½"; Blood pressure 155/100; Pulse: 72; Respirations 18. The patient was well developed and seemingly well nourished. He was notably apathetic and seemed preoccupied. The complexion was florid. The head and neck were

*Presented at the Annual Meeting of Arkansas Academy of General Practice, May 30, 1955, Hot Springs.

entirely negative. One 1 cm.—sized node was found in each axilla. The heart and lungs were physiologic. The abdomen was fairly flat. There was moderate tenderness in the epigastrium but no masses could be made out. The liver edge was just at the costal border and the spleen could not be felt. The rectal sphincter was tight. The genitalia and extremities were normal.

Laboratory: Fluoroscopy of the chest, urinalysis, stool and blood count were entirely normal. Electrocardiography demonstrated an abnormal form of ventricular complex and left axis deviation. Gastro-intestinal fluoroscopy and roentgenograms showed a prompt deglutition and no intrinsic defects in the esophagus. With the patient standing, the barium readily passed into a normal-appearing stomach. There was good peristaltic activity. No masses or craters were visualized. The pylorus was not remarkable. The patient was then placed in Trendelenburg position and pressure was applied to the epigastrium. Immediately the stomach ballooned through the esophageal hiatus, and this was readily demonstrated on a film. No cancer was present. A gall bladder examination was negative. The colon had many pedunculated diverticuli.

This patient was referred for study with a tentative diagnosis of cancer of the stomach!

Bleeding is a common manifestation of hiatus hernia. This varies from massive hemorrhages to virtually undetectable bleeding. The large hemorrhages may be caused by gastritis in the herniated portion of the stomach; at times, bleeding comes from gastric ulcers either at the constriction ring. Some anemic folks are completely symptomless as far as the G.-I. tract is concerned; their anemia is a great source of puzzlement to the physician until he performs a series of careful stool checks and finally finds blood. A G.-I. series may then disclose an otherwise symptomless hiatus hernia. The following two cases illustrate this:

Case No. 2: Mrs. S., aged 62 years. This white woman was in apparent good health except for mild dyspepsia after meals for 5 to 10 years. This was relieved by soda. The patient vigorously denied all other gastrointestinal symptoms as nausea, vomiting, jaundice, bleeding or abdominal pain. On October 2, 1951, without prior warning, the patient passed a large tarry stool. The patient was hospitalized, and the next day passed another large tarry stool. Following that the patient hemorrhaged almost daily. It was difficult to keep the blood count up despite repeated transfusions.

Social History, Past History, Habits, Family History and System Review were non-contributory.

Physical Examination: Height: 5' 3". Weight: 160 pounds. Temperature: 100°. Pulse: 85. Respirations: 20. Blood pressure: 100/60. There was bilateral coloboma due to surgery. All teeth were missing. The skin was pale. The patient was wan, listless, and had a suction tube in her nose.

Laboratory Data: Red Blood Count: 3,400,000. White blood count: 13,000. Hemoglobin: 68%. Hematocrit: 33%. Differential: Normal. Urinalysis was completely negative. Non-Protein-Nitrogen: 26.2 milligrams per cent. Total Protein: 5.7 grans per cent. A liver biopsy showed changes compatible with acute hepatitis, but no evidence of cirrhosis. No data indicated a bleeding diathesis.

Surgery: An exploratory laparotomy had been performed about two weeks after admission, and one week prior to my seeing the patient. Absolutely no bleeding site was discovered after a thorough search by three excellent surgeons.

Discussion: This was indeed a dilemma with a patient still bleeding after a thoughtful work-up, and no bleeding lesion noted even after surgical exploration. In reviewing the case, there was only one thing that had not been done, and that was to obtain gastro-intestinal X-rays. Despite the fact that the patient was still bleeding, she was taken to the X-ray department and given a swallow of barium in a semi-cumbent position. Nothing pathological was noted. However, when the patient was tipped downward into Trendelenburg position, a large hiatus hernia ballooned out. This was the culprit. When the patient was forced into just half lying in bed the stomach descended into the abdomen and the bleeding stopped.

Case No. 3: Mr. N., aged 69 years, white man. This patient had a chief complaint of diarrhoea of 25 years duration. The patient had tried innumerable remedies to stop the frequent loose, watery, mucous-containing stools. None of the usual therapeutics helped him. He had an anemia which varied from 3,500,000 to 4,000,000 red blood cells, and was hypochromic. Despite taking a large amount of iron, the anemia did not respond.

Physical Examination: Height: 5' 7". Weight: 144 pounds. Blood pressure: 110/70. There were no physical findings of note.

Laboratory Data: Disclosed renal glycosuria.

Course: The patient had a routine X-ray series, because of the diarrhoea, and a hiatus her-

nia was discovered. This was unquestionably the cause of the mild anemia, which had been present for years, and for which the patient had had treatment directed at his liver, bone marrow, and colon. Mild persistent anemia is frequently associated with hiatus hernia.

We are prone to think of the hiatus hernia as causing predominantly abdominal symptoms, and forget that inasmuch as the hernia is into the thoracic cavity, Dysphagia and a sense of food catching under the sternum are troublesome to many of these patients. This is often encountered and seldom surprises us. The physician is often confronted by another type of thoracic symptom: precordial pain; he must decide if it is coronary disease with its attendant poor prognosis or if it is a simulator. The following two cases were examples of how difficult this decision may be.

Case No. 4: A white, married, retired executive, 72, complained of discomfort in the chest for one year's duration. The patient stated that for about one year he had a vague sense of oppression in the chest. This was markedly exacerbated for the week prior to being seen. The oppression was characterized as a sense of burning and a sense of fullness underneath the sternum. The onset was fairly rapid. The discomfort lasted ten to 15 minutes. The offset was unusually rapid. These recurred from one to three times every day. The attacks could be brought on by bending over or reaching; they were relieved by standing or sitting on the edge of a piece of furniture in an almost erect position. The attacks did not seem to be related to exertion. There was no shortness of breath, edema, cough, sputum, or palpitations, or squeezing chest pain. The patient denied all gastro-intestinal symptoms as nausea, vomiting, diarrhoea, jaundice, constipation or abdominal pain.

Family, social, past and habit histories, and systemic review, were non-contributory.

Physical Examination: (Positive and pertinent negative findings only). Weight: 164 pounds; height: 5' 8"; blood pressure: 170/92; pulse 78. The patient was well developed and well nourished. The retinal arteries showed some arteriolo-venous nicking. There was a partial edentula. The ears and nose were not remarkable. There was no lymphadenopathy. The thyroid was very slightly enlarged. A few dry crackles were heard at the lung bases, but the lungs were not otherwise remarkable. The heart was not enlarged; there were no murmurs, thrills, or arrhythmias. The abdomen was soft and there were no palpable masses. External hemorrhoids were present.

Laboratory: Urine: yellow, pH 6, sp. gr. 1.007, albumin 2+, sugar 0, rare RBC and WBC in the spun sediment.

Blood: Red blood count: 5.2 million. White blood count: 12,500. Hemoglobin: 16 g. Polys: 58. Lymphs: 29%. Mono. 8%. Eos. 5%. Bas. 0.

Stool: Guiac negative.

Electrocardiogram showed no significant evidence of cardiac abnormality.

Six-foot film of the chest: Film of the chest revealed the cardiac silhouette to be at the upper limit of normal in size and not unusual in shape. The hilar markings were a little increased on the right. There were several small areas of calcification in the hilus. The peripheral lung fields were not remarkable. The right diaphragm showed a dome-shaped elevation measuring approximately 10 cm. \times 3 cm.; it probably represents an anomaly of the liver. No air bubble was seen above the diaphragm.

Course: The patient was scheduled for a gastric fill-up on the day following the above described physical examination. At 2 A.M. in the morning of the day after this physical examination the patient awakened with a sense of burning and a sense of fullness beneath his sternum exactly similar to the previous attacks. Standing up did not relieve this attack. Within a matter of minutes this pain increased in intensity and became overwhelming. The patient slumped to the floor and became unconscious. He was moved to a hospital. An electrocardiogram taken immediately after admission showed the typical changes of posterior myocardial infarction. The patient died 12 hours after admission. Autopsy permission was not obtained.

Case No. 5: Mr. H., age 65 years, white, married, complained of epigastric pain of one day's duration. He developed an achy pain in the right costovertebral angle at 2 A.M. on May 12, 1950. The pain radiated to the right flank and syphysis pubis. It increased in intensity and was soon accompanied by marked abdominal distention. The patient was hospitalized and urologic studies showed a stone in the right ureter. The distention persisted for ten days and subsided. On May 29, 1950, the patient suddenly developed a severe pain in the left lower chest anteriorly and in the retro-sternal area. It was achy and waxed and waned in intensity for one day, radiating to the left shoulder. It was somewhat increased by deep respiration and nitroglycerin failed to relieve it. There were no gastro-intestinal, cardiac or respiratory symptoms.

Social history, habit, past histories, and systemic review were non-contributory. Pulse was 76, respirations 20, temperature 98°, blood pressure 165/90. The patient was a well-developed, rather tall, slightly obese, ruddy-faced man who seemed acutely uncomfortable. Pupils reacted to light and accommodation. There was arteriovenous nicking of the retinal vessels. The nasal air passages were clear. The tympanic membrane was intact. There was complete edentula. The neck was supple. There was no lymphadenopathy. The heart was not enlarged; there were no murmurs, thrills or arrhythmias. The lungs were clear and resonant. The abdomen was protuberant; pressure on the epigastrium increased the retrosternal pain; the liver and spleen were not palpable, and there were no abdominal masses. Rectal examination and genitalia were not remarkable. There was no electrocardiographic evidence of cardiac disease.

Upper gastro-intestinal barium studies revealed a large reducible hiatal hernia without a short esophagus. No other pathology was found.

Course: The patient was encouraged to stand up and move around. Shortly thereafter the pain disappeared. It has since recurred occasionally on lying down.

In summary, the clinical symptoms of this disease tends to follow the obvious mechanical defect: discomfort on lying when the stomach herniates into the thoracic cavity with relief on standing when the hernia is reduced. The joker in this concept is that many cases do not follow this pattern but simulate other diseases, some of which are much more serious than hiatus hernia.

Every G-I series should include a careful fluoroscopic examination of the patient in the head-down position. With the patient lying supine gentle pressure on the abdomen will usually demonstrate an existent hiatus hernia. The hiatus hernia is to be differentiated from a dilated phrenic ampulla of the esophagus; the latter is not a hernia but a widened area of esophagus just above the diaphragm.

The treatment of most hiatus hernias is medical. The usual program consists of indoctrinating the patient about the mechanical defect. He will then realize that 8" or 10" blocks under the head of his bed makes sense—it is to keep the stomach in the abdominal cavity. For the same reason standing after eating is desirable since straining or any maneuver which will increase the intra-abdominal pressure will force the stomach through the diaphragm, the patient must be warned against straining at stool, lifting, coughing, vio-

lently, etc. Relief of some of the dyspeptic symptoms can be induced by small, frequent bland feedings, antacids and anti-secretory drugs. Many of these dyspeptic symptoms are due to gastritis and because of this this ulcer-like regimen is suggested. Some of the complications can be treated symptomatically as iron for the anemia, and occasionally blood transfusion in very severe cases.

Surgery and Peptic Esophagitis

Opposed to this fairly well understood and agreed on clinical picture, is the utterly confusing problem of surgery in hiatus hernia, particularly in the presence of the complication of peptic esophagitis. Peptic esophagitis is an inflammatory reaction in the lower esophagus due to the reflux of irritating gastric juices into the esophagus; this may lead to stenosis of the esophagus. In hiatus hernia there is a loss of a sphincter—like mechanism which keeps the irritating gastric fluids from flowing retrogradely into the esophagus.

Swallowing itself is a complicated procedure. Sanchez, Kramer, and Ingelfinger³ have recently reported on this mechanism; in the upper 7/8ths of the esophagus the swallowing complex consists of two major components: an immediate slight elevation of pressure due to the injection of food into the esophagus, and then later a strong peristaltic contraction. The distal esophagus has an upper ampulla in which the pressure wave slowly diminishes and a lower vestibule to which the pressures generated in swallowing are not transmitted. How this mechanism is deranged in hiatus hernia and peptic esophagitis is unknown. The work Donnelly reported in his Barclay Prize Essay clearly indicated that there was a so-called "hiatal valve" which let fluids go through prograde but resisted retrograde motion of the fluids⁴; he conceived of this valve action as due to the upper lip of the esophagus being held against the lower lip and supplemented to a variable degree by a diaphragmatic pinchcock. Dornhorst, Kent-Harrison, and Pierce deny the presence of any diaphragmatic pinchcock action but sustain the idea of a physiological cardiac valve.⁵

Aylwin has studied this problem from a somewhat different slant by collecting fluid from the esophagus and the stomach both day and night in contrast to studies mentioned above where X-ray pictures were made and intra-luminal pressures taken. He states "The damage found above a hiatus hernia is directly related to the enzyme activity of juices bathing the esophagus at night. This varies from basal levels to gastric hypersecretion in different individuals. Reflux during sleep differs from that occurring freely during the day,

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first because it arises only from the mucosa of the hernia while the remaining stomach juice is excluded by the hiatal margins, and secondly because salivation, the mainstay of esophageal defense, is absent at night so slow peptic digestion continues almost undisturbed. During the day reflux is quickly neutralized." This does not infer that the cardiac sphincter is operative in these patients, it infers that sleeping peristalsis is just too weak to push fluids back into the hernia.⁶ It should be mentioned here that Flood, Wills, and Baker¹⁴ were unable to demonstrate esophageal reflux in some of their cases with esophagitis but they do not deny that this might not be due to technical difficulties.

The idea that a cardiac sphincter exists is born out by several experimental studies. Hoag and his associates⁷ found in dogs that if the esophago-gastric junction is destroyed esophagitis develops even if 100% of the functioning stomach is destroyed. With an intact junction very small gastric resections protect against esophagitis. Watkins has reported experimental work in dogs in which he made a valve through a plastic procedure; this prevented esophagitis in dogs, and was tried on two humans.⁸

The diagnosis of esophagitis is established by symptoms, X-ray, and esophagoscopy. One of the best descriptions of the clinical picture is by Harman in a post-graduate lecture to the Royal College of Physicians⁹; he states, "The symptoms of oesophagitis are pain in the lower chest and heartburn. The chest pain is central and is described as being like wind, food stuck, or a pressing or burning sensation. When it is more severe it radiates to the left side and back. When it is severe, and especially when it is chronic, there is a constant feeling as if someone's knuckles were pressed into the back of the left lower chest. Usually it has no clear-cut relationship to feeding, though there is often enough to make the patient think it is a dyspepsia. Occasionally it quickly follows the taking of food, and then presents as a dysphagia. Sometimes dysphagia is severe and there may be obstruction. The pain lasts for periods of about half an hour. It does not show periodicity over weeks or months like a peptic ulcer.

"Heartburn is a lay term and is used by patients to describe various symptoms. I think most doctors would expect it to mean a burning or hot pain that rises from the upper chest into the throat and may spread into the jaws and mouth and be accompanied by flushing of the face and watering of the eyes. It feels as if some acrid fluid is being forced up the gullet, and the patient swallows re-

peatedly to keep this down. Regurgitation may indeed occur, but it is not common, and regurgitation is not necessarily accompanied by heartburn. It is most characteristic in this syndrome when it is made worse by stooping. Patients give up scrubbing floors, gardening, or putting, and dread the time they go to bed. Heartburn and chest pain may occur separated or together, and it is difficult to say where one begins and the other ends. There is no point in trying to make this distinction, for they are both oesophagus pains. Chest pain is felt when the lower part is affected and heartburn when it is the upper. One other common feature may be added, and that is rosacea in women. Several of my patients have been under dermatologists for years, and its association with indigestion is of course well known."

A good description of the radiological appearance of the short esophagus with ulceration has been written by Bernard Wolf.¹⁰ Its characteristics are absence of acute angulation where the esophagus enters the stomach, effacement of mucosal pattern, and free reflux of Barium from the stomach into esophagus unless stenosis was present. In Dawson's review of reflux esophagitis without shortened esophagus he lists four radiological signs: structure, ulcer crater, hiatus hernia and reflux of barium into the stomach.

Esophagoscopy has been performed on many patients with esophagitis. The procedure may be technically difficult because of areas of thinning of the esophageal wall and areas of rigidity of the esophagus. The experienced esophagologist readily recognizes esophagitis but there are cases in which biopsy is necessary to rule out carcinoma.

Assuming the diagnosis of peptic esophagitis to be established, one is then faced with the thorny problem of what to do about it.

Case No. 6: Mr. Y., a 70-year-old, white, married executive, was first seen on October 12, 1951, at which time his chief complaint was abdominal discomfort of 11 years' duration. The patient stated that he was in good health until approximately 1940, when he developed indigestion. This was characterized as an epigastric burning, which came on more often on lying down than standing. Eating seemed to precipitate this, also. He felt as though the food went down into the lower esophageal region, and then stopped. On belching, air might come up so violently that it brought food out with it. Occasionally the patient gets complete relief from the sticking sensation by vomiting. The vomitus contains no food; it is white and frothy. The patient does not relate these symptoms to anything other than food;

starvation seems to give rather complete relief; spicy foods seem to increase the discomfort. There had been no jaundice, bleeding, diarrhoea, or constipation.

Family History, Social History, Past History and Habits: Non-contributory.

Review of Systems: (Pertinent positive and negative findings only). The patient wears glasses. His ears frequently ache, especially the left side. He has a post-nasal drip. He has many hyperkeratotic areas in the skin. He has coughed a great deal, and thinks he has had chronic bronchitis. He has a considerable degree of pain in the right hip.

Physical Examination: Height: 5' 10". Weight: 165 pounds. Pulse: 68. Blood pressure: 124/80. Respirations: 16. The patient was a well developed, slightly stooped, white man who did not appear to be acutely or chronically ill. He was active and intellectually alert. A complete physical examination disclosed no notable findings.

Complete Blood Count: Red blood cells: 4,930,000. White blood cells: 5,750. Hemoglobin: 14 grams. Hematocrit: 43%. Polys: 62%. Lymphs: 31%. Monos: 5%. Eos: 2%. Basos: 0.

Urinalysis: Color: Yellow, clear. Specific Gravity: 1.010. Reaction: pH 5. Albumin: 0. Acetone: 0. Sugar: 0. In the spun urinary sediment were seen rare Epithelial cells and white blood cells, 4 red blood cells, and crystalline debris, per low power field.

Six Foot Chest Film: Negative.

Spine Film: Osteoarthritis, scoliosis.

Upper Gastrointestinal Series: The esophagus shows prompt deglutition. The stomach corresponds in shape to a sthenic habitus. There is a hiatus hernia which reduces itself on standing. There is good peristaltic activity throughout the stomach. No craters or masses are seen. The pylorus shows a perfect contour and tonicity. The duodenal cap fills well and is not tender or overquick. The small bowel forms are not remarkable. At 5 hours the stomach is empty and the distal end of the column barium is in the descending colon. Impression: Hiatus hernia.

Electrocardiogram: Negative.

During the year the patient continued complaining of an increase in his old symptoms. Upper Gastrointestinal Series were taken on May 29, 1952, and March 7, 1953, and again on November 12, 1953. On the November 12, 1953, films

there appeared to be an area of constriction more marked than on the previous films, and in location just above the hiatus hernia. It was felt that this probably represented a peptic esophagitis, but of course the possibility of neoplasm had to be entertained. Because of this, the patient was evaluated for surgery. The surgeons esophagoscoped the patient and found an area of constriction in the lower third of the esophagus; the wall appeared very thin and friable; it did not appear rigid. The 'scope could not be passed beyond this point, and it was felt that a biopsy would in all probability perforate the esophagus.

Course

This patient's case posed a difficult problem. He was having so much dysphagia and regurgitation that his nutrition was beginning to suffer. If surgery were performed we could not offer him assurance of a satisfactory result, even though the surgery was properly performed. Under medical therapy he had not done well. It was decided to continue his medical therapy and to put him in a hospital bed that could be elevated at the head. On a more vigorous medical plan the patient has not undergone any deterioration and feels that he may have improved somewhat. It was planned to use bouginage if necessary, but as yet the need has not arisen. Currently, the patient is able to eat liquids and very soft foods. He cannot eat large bites of particulate matter.

The preferential treatment is medical and is the same as described in the foregoing for hiatus hernia, esophagitis and stenosis. Benedict and Gillespie had 34 patients on good medical treatment which included bouginage; they were followed at least one year; their results were good in 17, fair in 15, and unchanged in 2.¹²

Despite good medical care some of these cases of esophagitis do poorly. The indications for surgery are better agreed on than what surgical procedure should be used. Sweet advocates surgery for four indications:¹³ obstruction, severe pain, bleeding, and perforation. There can be very little argument with these criteria. He used four procedures: limited esophageal resection, extensive esophageal resection with a proximal partial gastric resection, extensive proximal partial gastric resection and a minimal esophageal resection, and lastly esophagoplasty. These operations invariably destroy the esophago-gastric junction. Despite experimental evidence to the contrary, Sweet claimed a satisfactory result in 90% of his patients. Carver and Sealy¹⁴ reported the experience of treatment at Duke University; this comprised 130 patients; they recommended early re-

pair of sliding hiatus hernia which is accompanied by esophagitis resistant to therapy, subtotal gastric resection with repair of the hiatus hernia for patients with the triad of esophageal ulcer, hiatus hernia and duodenal ulcer, and in stenosis esophago-gastrostomy. In simple hiatus hernia, Lam and Kenney recommend surgical repair by a series of interrupted sutures placed posterior to the esophagus; in 20 repairs they had no recurrences.¹⁵

Conclusions

1. The problem of hiatus hernia without esophagitis was reviewed. Special emphasis was placed on diagnosis. It was stressed that although many hiatus hernias cause the classical picture of dyspepsia on lying down with relief on standing, the hiatus hernia is a great imitator and may simulate many serious upper abdominal and thoracic diseases.
2. Esophagitis as a complication of hiatus hernia is a controversial subject as to both etiology and treatment. The bulk of the evidence favors peptic regurgitation due to loss of the so-called cardiac valve as the causative agent. The perfect surgical therapeusis for this condition is yet to be devised.

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"Men, on their side, must force themselves for a while to lay their notions by and begin to familiarize themselves with facts."—Francis Bacon, Viscount of St. Albans.

— ★ Editorial ★ —

BRAINWASHING ON SOCIAL SECURITY

R. B. ROBINS, Camden

At the recent AMA meeting in Atlantic City a Michigan delegate introduced a resolution to petition Congress to permit physicians to enter Social Security on a voluntary basis. He stated that the younger physicians in his state were asking for such a provision. To many of us this means that a lot of brainwashing is going on in America to persuade our younger citizens to accept a way of life that is not American.

Let's call attention to a few pertinent points. Social Security is based on the concept of enforced retirement at age 65. As a rule physicians work until they die. A person cannot receive Social Security if he earns over \$1,200 a year. How many doctors fail to earn that much? So the point is that doctors would pay this tax all their lives and never receive anything in return. A physician who continues his professional activities to age 75 must keep right on paying the rising Social Security taxes.

These taxes right now amount to \$126 a year on \$4,200. It is being proposed at the time this is written (June 15) that these taxes be raised to \$176.40 for self-employed persons. It has long been advocated that the tax base be increased from \$4,200 to \$6,000. Please remember that it formerly was \$3,000, then \$3,600 and now \$4,200. So it is easy to see the trend. There is no assurance that Social Security taxes may rise in the future to 10, 12 or 15 percent of net income.

If physicians accept the philosophy of socialism by asking to be included in Social Security, then how can they logically oppose the nationalization of medicine which is the ultimate goal of those who have been outstanding in the promotion of the Social Security System?

There is an attitude of despair and defeatism in too many quarters in the profession. There are those who say that we are confronted with a world trend toward Socialism and that there is nothing that we can do about it. We need to conduct a renewed public relations campaign in American medicine to acquaint the younger members of the profession to the advantages of the free enterprise system in the American Way of Life.

President L. H. McDaniel, Tyronza, gained much attention for his state and for himself in his Chairman's Address at the Atlantic City meeting of the American Medical Association last June.

Here is what he had to say in a recent letter to A.M.A. headquarters:

"I have received clippings and comments from all over the world—several hundreds of them, in fact; some from London, one from Zurich, Switzerland, and one from Hong Kong, China, in Chinese. Arthur Godfrey gave my talk 15 minutes on his TV program; so did Warren Hull and so did Garry Moore. Had many letters from overseas GIs, who heard it on an overseas broadcast. About two per cent of my letters are from religious cranks who accuse me of sin in suggesting that man will live beyond the three score and ten. Another two per cent vilify me as a spokesman of 'the cruel medical trust.' Then another one per cent have some pet formula or elixir of life and want me to go in partnership with them—they would furnish the brains and I the publicity. About five per cent are dubious, but hopeful. The highest percentage of letters was very complimentary not only of me but the medical profession as well."

Congratulations, Prexy!

FROM THE STATE HEALTH OFFICER

The Arkansas State Board of Health has recently revised its Immunization Policies, and issued a manual of questions and answers to accompany the revision. Readers will be interested in one particularly notable change in these policies.

A new product, Tetanus and Diphtheria Toxoids for Adults, has been introduced. It will replace the Tetanus toxoid previously issued. It will be used to immunize adults for the first time, or to give them booster doses, against diphtheria and tetanus. It is used without preliminary Schick or toxoid sensitivity testing, which means a great saving of the time and effort of physicians and public health personnel. Arkansas is among the first states to introduce this new product, which was developed by the U. S. and Canadian Armed Forces and by the Massachusetts Health Department.

The development of a safe, easy way to immunize adults against diphtheria is particularly welcome in view of the steady increase in sus-

ceptibility of the adult population to diphtheria. Adults were formerly kept immune to diphtheria by repeated contacts with childhood cases of carriers. Since childhood diphtheria has been greatly reduced in recent years, immunity in adults is no longer being maintained, and a widespread epidemic among adults has become possible. Such an epidemic occurred in Copenhagen following World War II, and gave stimulus to the development of this new product for adult use. The product will be available to physicians on the same basis as other immunization products, from local health departments, or from the State Health Department in counties lacking public health personnel.

John T. Herron,
State Health Officer.

DOCTORS' DRAFT AMENDMENT EXEMPTS CERTAIN DOCTORS

A PHYSICIAN OR DENTIST, 35 years of age or older whose application for a commission in one of the armed forces, has ever been rejected for physical reasons cannot now be called involuntarily to military service, Dr. Frank B. Berry, Assistant Secretary of Defense (Health and Medical), said today, commenting on an amendment to extension of the Doctors' Draft Act approved at 7:10 P.M. (EDT) yesterday, June 30, 1955.

Dr. Berry said that involuntary active duty orders which were scheduled to be effective June 30, and which are addressed to physicians and dentists affected by the amendment, are being revoked if those concerned had not yet commenced travel in connection with their orders and if they desire to have their orders revoked.

Dr. Berry said that a physician or dentist, age 35 or more, whether he now holds a reserve commission or is a civilian, cannot be involuntarily called to active duty or inducted if, at any time, theretofore or thereafter, his application for a commission in one of the armed forces as a physician or dentist had been or is rejected solely on the grounds of a physical disqualification.

Such persons who were merely classified 4-F by their draft boards would not be affected by the new amendment, Dr. Berry emphasized. To be affected, a physician or dentist must have applied for a commission as a medical or dental officer in one of the armed forces and have been rejected on physical grounds.

"THE FINE PRINT"

Have you seen this in all the newspaper propaganda written to sell "Social Security" to the public?

Section 1104 of the Social Security Act reads: "The right to alter, amend or repeal any provisions of this act is hereby reserved to Congress." Did you notice that "**Repeal?**" This makes ridiculous the claim that OSAI is insurance. There is no contract. Not even a promise to pay. Unless money is dug out from future taxes of our children, OSAI cannot pay anyone anything.

We had better look to the principle of this scheme that we have borrowed from Central Europe.

Russian prestige has traveled the road of Socialism. We hope we are not headed in their direction.

THINGS TO COME—

AMA'S PUBLIC RELATIONS INSTITUTE
August 31 - September 1. Drake Hotel, Chicago.

**ARKANSAS ACADEMY OF GENERAL
PRACTICE ANNUAL FALL ASSEMBLY**
October 5 and 6. Lafayette Hotel, Little Rock.

SOUTHERN MEDICAL ASSOCIATION
November 14-17. Shamrock Hotel, Houston.

INTERIM MEETING
AMERICAN MEDICAL ASSOCIATION
November 30 - December 3. Boston.

**62nd ANNUAL MEETING ASSOCIATION OF
MILITARY SURGEONS**
November 7-9. Washington, D. C.

**POSTGRADUATE ASSEMBLY OF ENDOCRINE
SOCIETY**

"Endocrinology and Metabolism" is the subject for the seventh annual Postgraduate Assembly of the Endocrine Society, being held in Indianapolis, Sept. 26-Oct. 1, with the cooperation of the Indiana University School of Medicine.

Continuation study facilities of the Indiana University Medical Center will be utilized for the sessions at which 21 of the leading clinicians and investigators will be heard.

Information regarding the program, registration, etc., is available by addressing: Postgraduate Office, Indiana University School of Medicine, 1100 West Michigan St., Indianapolis 7, Indiana.

AMA DELEGATES' REPORTS

James M. Kolb of Clarksville, and I represented the Arkansas Medical Society as delegates to the American Medical Association's 104th annual meeting in Atlantic City June 6-10.

A general practitioner, Dwight H. Murray of Napa, California, who has been a member of the A.M.A. Board of Trustees for ten years and its chairman for the past four years, was unanimously elected president-elect of the A.M.A. He will succeed Elmer Hess of Erie, Pa., as president of the A.M.A. at the Chicago meeting in June, 1956.

I am reporting on a few of the actions taken by the House of Delegates at this meeting. One of the important subjects under discussion was osteopathy. To us it was a little surprising to see the number of delegates who were inclined to lend a helping hand to a "cult"—the osteopaths. A shift of just 11 votes out of the 182 cast would have given A.M.A. approval to members of the A.M.A. teaching in osteopathy schools. This matter, however, now rests in a cold pigeonhole for the time being. My fellow-delegate, Jim Kolb, told the House of Delegates in a very nice speech that he couldn't support a movement for us to bed-up with the osteopaths. He said "that if he did, he would be tarred and feathered when he returned to Arkansas."

Social Security. I think that Dr. Kolb will agree with me that there is a need for a more astute educational or public relations effort on the part of the A.M.A. to acquaint the younger doctors of our country regarding the fallacies of Social Security as compared to free enterprise insurance in providing for the doctor's own security. It is our feeling that the young doctors of our country are being gradually brainwashed to accept socialistic changes.

A delegate from Michigan presented a resolution calling for the A.M.A. to petition Congress to amend Social Security law so as to permit coverage of physicians on a voluntary, elective basis. He was asked why he did this and stated that it was due to pressure on the part of the younger physicians of his state.

To us this means the need of educating young physicians concerning Social Security and the real reasons why doctors don't desire coverage.

Other actions taken are as follows: It was recommended again that the United States withdraw from the International Labor Organization.

Regret was expressed that the Hoover Commission saw fit to alter or eliminate some of the recommendations of its Medical Task Force.

A resolution was adopted imputing bad faith to the medical program of the United Mine Workers Welfare and Retirement Fund in connection with administrative policy which interferes with free choice of physicians.

Dr. Kolb will give a report on a number of other actions of the House of Delegates.

R. B. Robins, Delegate.

Report of James M. Kolb, Alternate Delegate, A.M.A. Serving as Delegate in Absence of W. R. Brooksher.

It was my happy privilege to serve as a delegate to the American Medical Association in Atlantic City, New Jersey, June 5th to 10th, as a co-delegate with R. B. Robins. All Arkansas doctors should have that experience. That is the only way they could realize the wide range that his personality has radiated and the high esteem his ability has soared to. I predict that he has more honors in store in the near future.

As a delegate, I attended all the sessions of the House of Delegates and as many of the Reference Committee meetings as possible, appearing before five Committees, in support of the four resolutions introduced by the Arkansas Delegates as instructed by the action of the House of Delegates of the Arkansas Medical Society. These were as follows: No. 34 Hoover Report, No. 35 Section 8, Code of Ethics; No. 37 Federal Aid to Medical Education, and No. 57 Medical Care of United Miners Welfare Administration Clients. These were all acted on favorably by the House of Delegates and the stand taken by the Council of the Arkansas Medical Society last December concerning dispensing of glasses by Ophthalmologist was adopted.

There was a total of 83 resolutions introduced. It was impossible to go to all the hearings, as they were held simultaneously by the various reference committees, but by dividing the responsibility your delegates attended all controversial hearings and were, in a small way, able to help defeat them. Other than those mentioned by Dr. Robins in his report, the most serious one, was to move the A.M.A. office to Washington, D. C., thereby putting it under direct pressure of the Bureaucrats; another was the placing of the Public Health Service under a Military Status and making it a part of the Medical Draft Program. These were both defeated.

Resolutions were passed opposing the extension of the Doctor Draft Act; expansion of Veterans Medical Care to Non-Service Connected Dis-

abilities, other than Tuberculosis and Psychiatric Care; Consultation with Optometric Practitioners and teaching in their schools; opposing the interference of Governmental Regulations of the Polio Vaccine Program.

The report of the Medical Practice Committee was held over to the Boston Clinical Meeting, Nov. 28, 1955, for further study.

I would like to suggest and request that each member read the Abstract of Reports that started in the organizational section, of the Journal of the A.M.A. dated June 18, 1955.

James M. Kolb, Delegate.

Arkansas

TRAVELING

And Clipping Bits Here and There

From the A.M.A.'s Secretary's Letter:

A California paper talks about the new President-Elect.

"No one," the editorial said, "personifies more completely the average man's grateful concept of the family doctor, with his warm personal understanding of individual human needs, backed by sound training and unflagging devotion to his fellow men, than California's beloved and self-styled 'country doctor,' Dwight H. Murray of Napa.

"For more than half of his 66 years, Dr. Murray has maintained the rugged regimen of the general practitioner, ministering to all who needed him, keeping pace with the progress of his profession. Now his profession has bestowed upon Dwight H. Murray the highest honor it possesses. . . ."

NEW MANUAL COMING FOR DOCTOR ASSISTANTS

A new, 500-page textbook or training manual, especially helpful to the girl employed in a physician's office, will be published by W. B. Saunders and Company next January.

The book tentatively entitled "The Office Assistant—in Medical or Dental Practice," is being written by Portia Frederick, Long Beach, Calif., instructor of a two-year course for physicians' aides and laboratory technicians, and Carol Towner of the A.M.A. Public Relations Department.

The importance of the medical aide in creating good public relations for her physician-employer is stressed throughout the entire volume. Physicians training new aides, medical assistants already

working for doctors, teachers of training courses in the medical-dental field, and medical societies carrying on short teaching courses for assistants, will find the book of value.

COPIES OF HIPPOCRATIC OATH AVAILABLE

A striking, two-color offset reproduction of the revered Hippocratic Oath is now available from the American Medical Association's Order Department, \$1 each, postpaid.

Printed on quality Crane parchment stock, the reproduction measuring 11¾ by 15¼ inches is suitable for framing. Many physicians are placing copies of the oath in their offices and waiting rooms.

11,546 PHYSICIANS AT ATLANTIC CITY MEETING

A breakdown of registrations at the recent A.M.A. session in Atlantic City shows that a total of 11,546 physicians registered at the meeting.

By states, Pennsylvania had the highest number of registrations, 2,494; followed by New York with 2,054; New Jersey, 1,745, and Ohio, 414.

CHICAGO TRIBUNE HITS DOCTOR DRAFT

One of the best editorials ever written against the doctor draft bill appeared in the Chicago Tribune on June 10.

"The real reason for the extension of the doctor draft is disgraceful," the editorial said. It closed with this:

"The doctor draft is unjust. Its extension would mark the first time in our history that any group of citizens has been singled out for conscription in peace time because of their professional skill."

"Taxation has already become confiscation," A.M.A. Past President E. J. McCormick told the graduating class of Seaton Hall University.

"A continually expanding federal government and loss of states' rights spells disappearance of religious freedom, freedom of speech and of the press, and of individual rights, and **eventual loss of democracy.**"

Critical of government-generated dependency, Dr. McCormick said "many young men and women today in their philosophy do not resemble our forefathers who made a great country from a virgin wilderness. They are likely to think not of what they may accomplish to become independent, but of pensions, social security, and fringe benefits."

Dr. McCormick urged the University to refuse to solicit funds for the Medical School from the Federal government.

He urged them to build the American Way.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28-September 2, 1955, inclusive, at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

PUBLIC Physician Personal Patient RELATIONS

The following is a copy of "Prayer of the Physician" reprinted from the South African Medical Journal by the J.A.M.A.:

PRAYER OF THE PHYSICIAN

O God, I pray that I may have absolute intellectual honesty; let others fumble, shuffle and evade, but let me, the Physician, cleave to the clean truth; assume no knowledge I have not, and claim no skill I do not possess. Cleanse me from all credulities, all fatuous enthusiasms, all stubbornness, vanities, egotism, prejudices, and whatever else may clog the sound processes of my mind—those be dirt; make my personality as aseptic as my instruments. Give me heart, but let my feeling be such as shall cover over me as an investment of power, to make my thoughts clear and cold as stars, and my hand skillful, strong as steel. Deliver me from professionalism, so that I may be always human, and thus minister to sickly minds as well as to ailing bodies. Give me the joy of healing. I know how far short I am of being a good man, but make me a good doctor. Give me courage, but hold me back from over-confidence. Let me so discharge the duties of my office that I shall not be ashamed to look man or woman in the face, so that when at death I lay down my task I shall go to what judgment awaits me strong in the consciousness that I have done something towards alleviating the incurable tragedy of Life. Amen.

DOCTORS FROM 12 NATIONS TOUR U. S. ATOMIC MEDICAL FACILITIES

A group of 25 leading doctors and surgeons from 12 nations on June 20 began a 37-day tour of hospitals, research centers, universities and U. S. Atomic Energy Commission installations in the United States. The tour is sponsored by the U. S. Department of State, the U. S. Atomic Energy Commission and the Leaders Program of the

American Council on Education as part of President Eisenhower's "Atoms for Peace" program.

The group will visit Washington, D. C.; Oak Ridge, Tenn.; Chicago, Ill.; Cleveland, Ohio; Buffalo, N. Y.; Rochester, N. Y.; Boston, Mass.; and New York City, N. Y. The tour will end on July 26.

REMEMBER WHEN?

"Last October I said this to the American Legion Convention:

"The first principle, following inevitably from the obligation of citizens to bear arms, is that the Government has a responsibility for and toward those who suffered injury or contracted disease while serving in its defense.

"The second principle is that no person, because he wore a uniform, must thereafter be placed in a special class of beneficiaries over and above all other citizens. The fact of wearing a uniform does not mean that he can demand and receive from his Government a benefit which no other citizen receives. It does not mean that because a person served in the defense of his country, performed a basic obligation of citizenship, he should receive a pension from his Government because of a disability incurred after his service had terminated, and not connected with that service.

"It does mean, however, that those who were injured in or as a result of their service are entitled to receive adequate and generous compensation for their disabilities. It does mean that generous care shall be extended to the dependents of those who died in or as a result of service to their country."

"I am very confident that the American people, including the overwhelming majority of veterans themselves, approve these principles and in the last analysis will support them." — The Public Papers and Addresses of Franklin D. Roosevelt, Volume Three, 1934, Veto of the Appropriation Bill, Page 175.

Obituary

J. J. BURLESON, 79, died at his home in Antoine on June 4. He graduated from the University of Arkansas School of Medicine in 1901. Survivors include his widow, Mrs. Annie Mitchell Burleson; two sons; three half-brothers, and three half-sisters, and a grandchild. Funeral services were held at the Antoine Baptist Church June 6. Burial was in the Brockton cemetery near Delight.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

EMOTIONAL PROBLEMS IN THE TREATMENT OF TUBERCULOSIS

By FRANK E. COBURN, M.D., Editorial, *The American Review of Tuberculosis*, February, 1955

The fact that 35 to 50 per cent of patients with tuberculosis do not complete the residential treatment of their disease is striking evidence that something is awry with the handling of these patients. The treatment of the disease tuberculosis is tremendously improved but, if the emotional problems of the diseased people are improperly handled, they do not and cannot cooperate in the treatment. Not only are the advantages of the improved therapy lost, but these patients return to their communities to become sources of infection.

The two main contributions psychiatry can make in this situation are: a general attitude toward people with greater understanding of the role anxiety plays in shaping behavior; and techniques for finding out the patients' concerns so that they can be relieved.

The diagnosis of tuberculosis is inevitably an anxiety-producing situation for the patient, as it may also be for the physician. The physician knows about tuberculosis and what would be anxiety-producing to him if he found he had the disease. Therefore, in a conscious endeavor to relieve the patient's anxiety (but really probably to relieve his own), he is apt to attempt to reassure the patient about those things which would have made him anxious. This is futile, if not pernicious, as the patient's knowledge of tuberculosis and his personality is different from that of the physician, his personal problems are different. The anxiety the diagnosis produces in him is distinct and unique to him. It must be assumed that anxieties are produced in him, and then he must be induced to talk about them. To do this, we must remain silent at first. This increases the patient's anxiety to the point where he may ask questions. If he does not do so—after a few minutes of silence we may ask—what does this mean to you, or, how do you feel about this. This encourages him to talk. Rushing in with reassurance is avoided until the major part of his concerns is brought out, in order not to cut off discussion of them because they usually come last.

Reassurance must not go beyond our own certain knowledge. With the rapid changes in tuberculosis therapy, the length and method of treatment are uncertain; and the patient must not be given certainty when there is none. Setting of dates and duration of treatment is especially to be avoided, as if the time set is not fulfilled, it undermines his confidence in all the tuberculosis treatment team and results in diminished cooperation if not flight from therapy. The patient can be reassured that treatment has greatly improved and that he will be treated until he is well, although the exact time is uncertain.

In the sanatorium certain things are expected of the patient, although these may never have been analyzed from an emotional point of view. The patient is asked to give up his possibly hard-earned maturity. No longer is he to be the active, independent, giving parent or adult. He is to become passive, dependent, and receptive. He is to lie quietly, let others do things for him, and to do little or nothing for others. This is a tremendous change in his way of living, and the ease with which the patient makes this change depends upon his past history of dependency and maturity, his personality structure, and his habitual techniques of relieving the anxiety to which we are all prey.

To some people, giving up of maturity and relaxing into dependency is regarded as a blessing. They have maintained or achieved their maturity with difficulty—or not at all—and it is a great relief to have nothing expected of them. These patients may appear to be "good" patients in the sanatorium, but the difficulties in rehabilitation are obvious. However, these patients may encounter difficulty in the sanatorium. Their continual dependent demanding may lead to rejection by the staff—so, at the same instant, regression to a childhood level is demanded and fault is found for doing so. Another type of patient has grown up despite his parents who tried to keep him immature and dependent. He has had to go through a rebellion at adolescence. Here is the sanatorium staff playing the parental role all over

again. The patient is apt to react with his pattern of adolescent revolt, which leads to breaking of regulations or flight from the hospital. Another type of person has relieved his anxieties by action, whenever he has been upset. In a tuberculosis sanatorium, his anxieties are greatly increased by his fear of the disease, his concern about his family situation, and his economic helplessness. At the same time, his usual defense of activity is taken away. We think of the dangers of tuberculosis as being a stimulus to treatment cooperation but, if the anxiety of the patient under treatment is greater than that which he has about his disease, he may break off the treatment.

Some patients run into difficulty over the deprivation in the sexual sphere produced by the treatment situation. To some it is a matter of relief of physical tension which, if not relieved, gives rise to anxiety, emotional tensions, and restlessness. Possibly more important is the emotional loss. To many people, sexual activity is the proof that they are fully loved by someone, and the loss of this only source of self-esteem produces too much emotional disturbance to be tolerated.

In the types cited above—and there are many more—understanding of the patient's emotional problems and the flexible adaptation of treatment to them is necessary if the patient is to rest or to complete his treatment.

The rehabilitation of patients after treatment is another area in which emotional factors are predominant. Here, in essence, we try to undo the regressed, immature, passive, receptive, and dependent role and ask the patient to become mature, independent, and productive again. Some difficulties can be alleviated by allowing the patient to maintain some maturity during the treat-

ment. By presenting him with alternatives in planning his treatment, the support of his family, et cetera, we may nurture his self-esteem and the feeling that he can direct his own affairs. The amount of problem left at the time of rehabilitation depends on the personality of the patient, his degree of maturity before becoming ill, the degree of regression in the hospital, his methods of handling anxiety, the amount of tension and acceptance at home, residual symptoms, and the fears of recurrence. Thus, in the diagnosis, the treatment, and the rehabilitation of people suffering from tuberculosis, emotional factors are of paramount importance.

The major technique psychiatrists have to offer is simple in words—Get the patient to talk about himself. Most people enjoy the opportunity but may avoid the significantly disturbing areas. We must learn to listen quietly, sympathetically, and never by word, sigh, or gesture express condemnation of the patient. If we do, he just won't talk to us. He may tell us things which are unacceptable to our moral standards. It is not our job to re-make his character but to treat his tuberculosis. Patients may talk a little and then stop. Here a nudging technique is needed; a simple "and then" may start him off again. Or repeating his last phrase, or asking "How do you feel about that?" In all of these, it is to be noted that no new ideas have been introduced but the opportunity to talk was given. These techniques are equally applicable to case finding, medical management, and to rehabilitation.

The goal is a patient who understands his disease, who accepts a treatment which does not violate his personality, and who returns to the community as a mature, responsible, productive adult.

Proceedings of Societies

Quoted from the Fifth Annual Rural Health Conference held at Little Rock June 28-29.

"Arkansas is setting the pace for the nation," says Aubrey D. Gates, Chicago, field director of the Council on Rural Health, American Medical Association.

"This is the first state conference to set up a milk bar demonstration. Many state groups are promoting additional consumption of dairy products in many ways."

He points out that milk and its products are the Number One health foods for people of all ages

in all walks of life because of their "built-in" minerals and vitamins in the natural state. Unless people are properly fed, he declares, "you can't build good health."

The Tri-State Medical Society meets Sept. 28-29 in Texarkana, at the Grim Hotel. W. B. Harrell is president; Karlton Kemp, secretary-treasurer, and F. G. Thibault, El Dorado, is vice-president for Arkansas.

The two-day program includes: R. L. Sanders, Memphis; W. R. Mathews, Shreveport; Mr. Rob-

ert L. King, Washington; John C. Burch, Nashville; Joseph W. Kelso, Oklahoma City; James Henry DeWeerd, Rochester; and Richard V. Elbert, Little Rock.

Members of the Advisory Committee to the Perry County Rural Health Center Project, and their wives, were overnight guests of Mr. Winthrop Rockefeller at Win-Rock farm Saturday, July 9, and attended the dedication of the Clinic at the Sunday afternoon program on July 10. The list includes: James T. Wortham, Little Rock; Louis K. Hundley, Pine Bluff; Ben H. Saltzman, Mountain Home; James M. Kolb, Clarksville; Henry W. Thomas, Dermott; Fount Richardson, Fayetteville.

The new Clinic is now in operation with Austin D. Gullet, a native of Perry County, and a graduate of the University of Arkansas Medical School, in charge.

ARKANSAS RADIOLOGICAL SOCIETY

May 30, 1955

The Arkansas Radiological Society held its annual breakfast meeting at Hot Springs, on Monday, May 30, 1955.

Members present: Burton, Pool, Ward, Klein, Scruggs, Ed Gray, Wm. Gray, McDonald, Anderson, and Norton.

Guests present: Dr. William Yarbrough, Greenville, Miss., and Dr. Fred Hodges, Ann Arbor, Mich.

The minutes of the meeting of March 11, 1955, were approved without reading, having been sent to all members. Treasurer's report revealed a balance on deposit in the Worthen Bank & Trust Co., Little Rock, on May 11, 1955, of \$389.86.

President Burton introduced Dr. Fred Hodges, University of Michigan, and Dr. William Yarbrough of Greenville, Miss.

President Burton reported on his presentation to the Arkansas Rehabilitation Commission of the fee schedule adopted by this Society at the meeting March 11, 1955. A motion (Norton-Gray) was adopted that would allow Dr. Burton to vary from this schedule, as much as 50 per cent if necessary, in his dealings with the Rehabilitation Commission.

Dr. Burton reported on efforts toward establishing a section of Radiology in the Arkansas State Medical Society and urged everyone to ask his delegate to support this action.

Dr. Burton then made note that Drs. Meschan, Brogdon, and Blake would be leaving the state and expressed regrets at their leaving, with good wishes for success in their new positions. It was announced that Dr. Egner is to be associated with

Dr. Scruggs at the Baptist Hospital and that Dr. Hames is now in private practice at 2607 Southside Drive, Brownwood, Texas.

Dr. Burton deferred appointment of a chairman for the Scientific Program Committee to replace Dr. Meschan, saying this would be announced later.

Election of officers was held. The officers for 1955-56 are:

President.....	George Burton, El Dorado
Vice-President.....	Ed Gray, Little Rock
Secretary-Treasurer.....	Joe Norton, Little Rock
Executive Council Member—	
3-year term (to 1958).....	Joe Scruggs, Little Rock
2-year term (to 1957).....	Cyrus Klein, Texarkana
1-year term (to 1956)...	Ernest Mendelsohn, Fort Smith

Joe A. Norton,
Secretary-Treasurer.

WOODRUFF COUNTY

The Woodruff County Medical Society met June 24, at the Morris Clinic in McCrory.

James W. Headstream, Little Rock urologist, spoke on "General Practice Urological Problems."

Those present were John W. Morris, Fay Millwee and Fred C. Inman, Jr., of McCrory, and Frank Maguire, Sr., Frank Maguire, Jr., and C. E. Dungan, of Augusta.

The September meeting will be held on Dr. Maguire's houseboat on the White River near Augusta.

PERSONALS AND NEWS ITEMS

C. W. Jackson, a native of Walnut Ridge, and a graduate of the University of Arkansas Medical School, has returned from a 3-year stint with the Armed Forces, and opened offices in Judsonia.

Chas. Dixon, Gould, is the retiring president of the 50-Year Club of the Arkansas Medical Society, and he presided at the recent meeting held in Hot Springs. W. H. Mock, Prairie Grove, was installed as president for the coming year.

Hal Dildy, Little Rock, has returned to his practice, from service with the Armed Forces.

J. H. McCurry, perennial secretary-treasurer of the Craighead-Poinsett Medical Society, was honored by that body with a complimentary trip to the American Medical Association meeting in Atlantic City in June.

John Cash, a University of Arkansas graduate of 1954, opened offices in Corning, after finishing an internship at Hillcrest Hospital in Tulsa.

James Huskins, Siloam Springs, is new president of the Ninth Councilor District Medical Society which met in Cave Springs July 16. Ross Fowler, Harrison, is vice-president, and Stanley Applegate, secretary-treasurer.

Re-evaluation of Conization of the Cervix, by M. C. Hawkins, Jr., Searcy, which appeared in the Southern Medical Journal, April, 1955, was reprinted in condensed form in the June number of Modern Medicine.

Dwight W. Gray opened an office in Marianna July 1. He finished a year's course in surgery at Charity Hospital, Monroe, La., in June, and returned to his native state.

Mrs. Robert Fee Hyatt, Monticello, was honored recently as Arkansas' Mother of the Year, at the May 1-3 meeting in New York. She is the mother of two physician sons, Robert C. and Lewis Hyatt.

Three practicing Arkansas physicians have been approved to use radioactive isotopes for diagnostic and therapeutic uses by the U. S. Atomic Energy Commission. The first license was to the University of Arkansas School of Medicine, and the first to a private physician was to past-president, W. R. Brooksher, of Fort Smith. J. Harry Hayes, and Joe Norton, both of Little Rock, have been licensed recently.

C. S. Wilson, Siloam Springs, was honored in Conway, Mo., by a former classmate, J. W. Lindsay, on July 10. The occasion was the 50th anniversary of their graduation from the St. Louis University Medical Department. These "Country Doctors" have kept up a close friendship through the passing years.

W. O. Greene, Jr., and I. L. Carlton opened offices in the Chickasawba Clinic in Blytheville on July 4. Both are native Arkansans, and graduated from the University of Arkansas School of Medicine.

Hilliard R. Duckworth and Jim Bethel are opening clinical offices in the Piggott Hospital for the general practice of medicine. Wylie E. Turner who has been working there has entered a Memphis Hospital for treatment of a war-time back injury.

F. G. Thibault spent some days in an El Dorado Hospital, following an ant sting on July 14.

Curtis B. Clark opened a Sheridan office during July. A World War II veteran, he has recently completed an internship at Arkansas Baptist Hospital.

BOOK REVIEWS

Title: Bickham-Callander Surgery of the Alimentary Tract, Volumes I, II and III. Richard T. Shackelford, M.D., Assistant Professor of Surgery, Johns Hopkins University School of Medicine; Assisted by Hammond J. Dugan, M.D., Assistant in Surgery, Johns Hopkins University School of Medicine. Pp. 2,575. Illustrations 1,705. \$60. W. B. Saunders Company, Philadelphia.

Author Shackelford pays tribute to Bickham-Callander in this three-volume text, but the child wouldn't know its own father, or its grandfather. The revision has been complete, and while the older Bickham guided well the surgeon of an older period, the excellent illustrations of this book are definitely more lucid, and easier understood. The book is complete in the detail of almost every operation on the esophagus, stomach, and bowel. The descriptions are orderly, clear, concise, and complete. Pitfalls in surgery are mentioned with proper precautions, and treatment given, lest some enthusiastic surgeon assume that this is a surgery-made-easy text. On the other hand, when gastric resections, the pyloroplasty, bowel resections are so clearly outlined, it makes a reviewer wonder why surgeons think they are a special breed!

The type is large, the illustrations profuse, and revealing. The index is excellent, one of the few features, incidentally, which recalls Bickham's. Any medical reader who will spend time and application with this text will be amply rewarded.

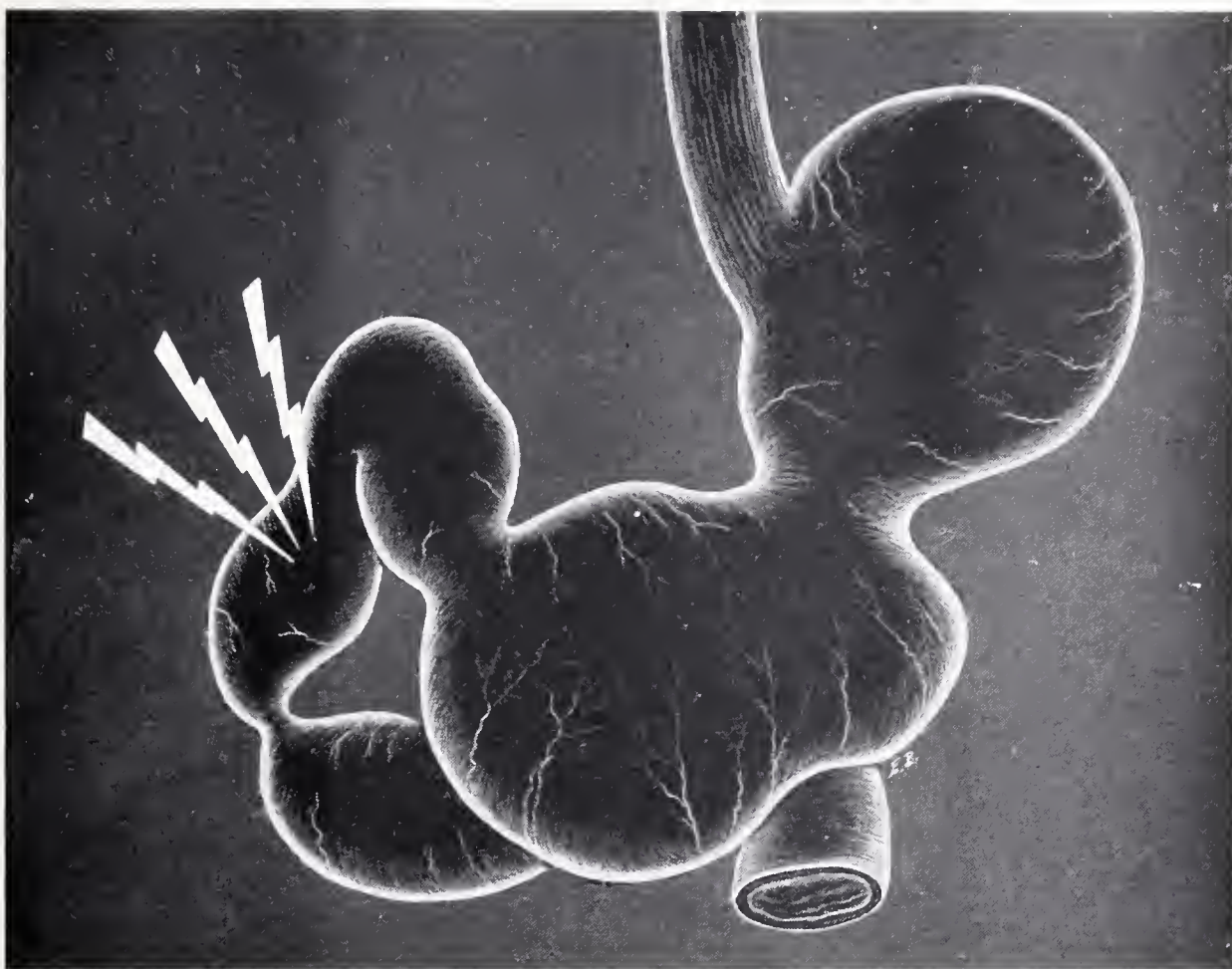
Obstetrics: J. P. Greenhill, Senior Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Eleventh Edition, W. B. Saunders Company, 1955, Philadelphia and London, pp. 1,088, 1,170 illustrations on 910 Figures, 144 in color. \$14.00.

This book is divided into two parts. The first contains the Physiology of Reproduction, Pregnancy, Labor, and the Puerperium. The second part contains the Pathology of Pregnancy, Labor and the Puerperium. For greater ease in reading, the book is printed in double columns. At the end of each chapter, there is an adequate list of references, with the authors listed alphabetically. The index of 43 pages is well organized, so that one can easily find the subject of immediate concern.

Much new information has been added to the present edition, including that concerning abruptio placentae, and the severe hemorrhages associated with an insufficiency of Fibrinogen. Many practical points are given, such as the recommendation that 10 Grams of Fibrinogen—sufficient to treat one patient—be available in each hospital which cares for obstetrical patients.

New material is included concerning Choriocarcinoma, the Lower Nephron Syndrome, Asphyxia, Pulmonary Hyaline Membrane, and Retrolental Fibroplasia. Since the author is editor of the **Year Book of Obstetrics & Gynecology**, he has access to a wealth of current literature, but he has also asked the assistance of experts in the various branches of medicine for correlation of certain specialized information. The text is therefore authoritative.

Entirely new chapters have been added concerning Roentgenology in Obstetrics, Analgesia and Anesthesia,



Abnormal Motility as the Cause of Ulcer Pain

Until recently the general opinion was held that ulcer pain was primarily caused by the presence of hydrochloric acid on the surface of the ulcer.

Present investigations^{1,2} on the relationship of acidity and muscular activity to ulcer pain have led to the following concept of its etiologic factor:

"... abnormal motility² is the fundamental mechanism through which ulcer pain is produced. For the production and perception of ulcer pain there must be, one, a stimulus, HCl or others less well understood; two, an intact motor nerve supply to the stomach and duodenum; three, altered gastro-duodenal motility; and four, an intact sensory pathway to the cerebral cortex."

Pro-Banthine[®] has been demonstrated consistently to reduce hypermotility of the stomach and intestinal tract and in most instances also to reduce gastric acid-

ity. Dramatic remissions¹ in peptic ulcer have followed Pro-Banthine therapy. These remissions (or possible cures) were established not only on the basis of the disappearance of pain and increased subjective well-being but also on roentgenologic evidence.

Pro-Banthine Bromide (Beta-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) has other fields of usefulness, particularly in those in which vagotonia or parasympathotonia is present. These conditions include hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm.

1. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.

2. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.

SEARLE

Fetal Erythroblastosis and the Rh Factor, Diseases of the Nervous System, Induction of Labor and Prolonged Labor.

The discussion of the psychological aspects of pregnancy and labor is unusually helpful in this day of stress. The explanation of the management of labor is comprehensive.

The book would be an excellent addition to the library of any physician.

Handbook of Pediatrics: Henry K. Silver, M.D., Associate Professor of Pediatrics, Yale University School of Medicine; Henry C. Kempe, M.D., Assistant Professor of Pediatrics, University of California School of Medicine; Henry B. Bruyn, M.D., Assistant Clinical Professor of Pediatrics, Stanford University Medical School. 1955. Pp. 548. First Edition. Limp binding. Lange Medical Publications, Los Altos, Calif. \$3.00.

This handbook is provided for quick reference in Pediatrics for a busy physician or student. Its small size adds to this convenience, but it is necessarily abridged. Usually only the most acceptable and time-tested methods and treatments are given. Tables are used to a considerable extent. There are few references.

Sports Injuries: Christopher Woodward. Pp. 128. Illustrated. Max Parrish, Publisher, London. Importers: Tract and Field News, Los Altos, California. \$3.00.

Dr. Woodward has furnished a handbook cataloging the various sports injuries. As the volume is intended for trainers and coaches, it does not discuss treatment, rather it gives what the author considers the only treatment. Physicians will find the book a little out of date, and in the characteristic style of the English writer. It can give considerable help if a Physiotherapist wishes to develop a certain set of muscles.

"Hey Groves' Synopsis of Surgery," edited by Sir Cecil Wakeley, Bt., K.B.E., C.B., LL.D. Fourteenth Edition. Williams and Wilkins Company, 1954, Baltimore, Md. Pp. 651.

This is the first new edition of Groves' Synopsis of Surgery in seven years. The changes in treatment and the growth of the various branches of surgery have necessitated rewriting much of the book by the present editor. The text as it appeared in 1908 attempted to present the diagnosis and treatment of surgical conditions in so concise a manner as to be of value as a review for students and a quick reference for the busy practitioner.

The book follows the traditional arrangement of subjects with the initial chapter on Inflammation and Suppuration and proceeds to chronic diseases, new growths, injuries and diseases of the various anatomical parts. Each chapter includes the definition, etiology and treatment of the disease or condition considered. Although in outline form the material is comprehensive.

As you might expect in a book of this type there are omissions. One of the more important is the failure to indicate the prophylactic use of tetanus anti-toxin or the administration of toxoid in those who have been immunized. The text is adequately illustrated with semi-diagrammatic drawings.

V. O. Lesh.

Muscular Dystrophy: Proceedings of the 3rd Annual Conference. Originally published American Journal of Physical Medicine, Vol. 35, No. 1, 1955. Pp. 324. Illustrated. Muscular Dystrophy Associations of America, Incorporated, 39 Broadway, New York 6, N. Y.

Interesting chiefly for its laboratory data on the physiology of the disease. It records considerable data on muscular chemistry, the calcium, glycogen and potassium content, and their effects. Useful for biochemists as well as physiologists.

The Human Adrenal Cortex: Edited by G. E. W. Wolstenholme and Margaret P. Cameron. Ciba Foundation Colloquia. Vol. VIII. 1955.

Although the widespread usage of the "conference type" meeting with published minutes is a useful form in which to cast current knowledge, it suffers from certain defects. The colloquium under consideration is rather a superior one, though, and may exemplify the highest order to which this kind of endeavor may arrive. It suffers from that defect which one might suspect, of knowledge so massive that it is both unwieldy and undigestible.

In the present volume, one finds data ranging from objective morphological findings on structure of the adrenal cortex to general physiologic and dynamic adrenal relationships; as an example of the latter, there is a section on cortical function of combat infantrymen in Korea. As well as adding advances in other areas, the following are chosen as evidence of specific advances in the knowledge of the adrenal cortex: the functional significance of the adrenal pattern may be learned by combined histologic and biochemical studies; a difference in phosphatase activity in different cortical zones in the human adrenal, with an alteration in alkaline phosphatase in stress situations, is discussed; a satisfactory method of determining blood androgen has been worked out; there is further definition of the new adreno-cortical hormone, aldosterone, which has been extracted in increased amounts from animal adrenals, and its successful use in Addison's disease; there is increased confirmation of a close corticomedullary relation in the work on ACTH release by adrenaline; a spontaneous diurnal variation in adrenal cortical activity has been shown to be present in man; in contrast to what was previously thought, ascorbic acid deficiency does not bar adrenal cortical secretion but can stimulate it; the adrenalectomized patient can now be maintained in good health with adrenal cortical hormones; an accurate record of the perceptual changes which occur in patients receiving ACTH has been obtained, and concurrent biochemical and psychological studies of the response of the adrenal to stress are underway.

Both Volume VIII and this discussion may seem far afield from the activities of the general practitioner of medicine. This is not so. Unfortunately, since it is highly complex, the field of the adrenal cortex is vitally important to all aspects of medicine as has again been brought into focus by work on ACTH and cortisone. While a considerable amount of the present data may be so obscure as to escape the ordinary knowledge of the general practitioner of medicine, the background material should, nevertheless, be studied by all.

Anderson Nettleship.



..... The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

SEPTEMBER, 1955

No. 4

WHAT'S NEW IN NEUROLOGY*

By WILLIAM K. JORDAN, M.D.

Department of Neurology, School of Medicine, University of Arkansas

Twenty years ago, the physician confronted with the problem of treating a patient with a medical neurologic disorder was justified in assuming an attitude of therapeutic pessimism. In the intervening years, the situation has undergone a remarkable change. For instance, infections of the nervous system such as meningococcal meningitis, and even tuberculous meningitis, can be treated now with much success by chemotherapy and antibiotics. The use of penicillin has reduced the incidence of neurosyphilis and, when it does occur, is very effective in arresting the progress of this affection of the nervous system. The Salk vaccine gives promise of preventing poliomyelitis in 60 to 90% of individuals and is a major advance in control of the virus infections of the nervous system.

These advances have come to neurology from other fields of medicine. Within neurology itself, contributions have been made, particularly in the control of the convulsive disorders. In 80% of the patients suffering from one of the forms of epilepsy, seizures can be satisfactorily controlled by use of appropriate chemical therapy.

In addition to this therapeutic progress, our understanding of the underlying mechanisms of neurologic disorders has gone forward, as has our knowledge of the way in which the nervous system functions normally. These advances, as well as those made in therapeutics, have recently been summarized for the general practitioner.^{1 2}

In the present review several new observations pertinent to vascular diseases of the brain and to our newer knowledge of the pathological chemistry and therapy of one of the degenerative diseases of the nervous system, namely hepatolenticular degeneration, will be described. These studies are offered as examples of the progress being made in our understanding of two important classes of neurologic disorders in which it is

usually considered that little or no improvement in our knowledge is being made.

Vascular Disease of the Brain

At present, treatment of cerebrovascular disease, once it has developed, is not satisfactory. Hence, any information that opens up avenues for its prevention is useful. A report has appeared recently which may well have important implications for prevention of this common disorder of the nervous system, as well as for its therapy.

Wilson and his associates³ in Philadelphia studied a series of 542 patients in whom evidence of an acute cerebrovascular accident was found at autopsy. The medical history, clinical examination or autopsy gave evidence of cardio-circulatory insufficiency in 83 per cent of these patients. These authors believe that their findings indicate that systemic circulatory inadequacy plays an important part in the causation of cerebrovascular accidents, and that preventive measures and therapy should be oriented toward maintaining and restoring general circulatory efficiency to as great a degree as possible. Their experience with stellate-ganglion block has not been as favorable as that of others, and they point out that a number of patients with cerebrovascular accidents show a gratifying degree of spontaneous recovery, and that, therefore, evaluation of results of therapy is difficult in this disorder. They remark that it is possible that some of the effects of stellate-ganglion block may be the result of improvement of systemic circulatory efficiency, since improvement after block has been reported in paroxysmal atrial tachycardia and atrial fibrillation. They do not consider the condition of the general cardiocirculatory state to be the sole factor, but rather one of the more important factors, in the etiology of cerebrovascular disease.

Cerebral angiography has made possible a clearer understanding of the syndrome of partial

* Presented at the Seventy-ninth Annual Session of the Arkansas Medical Society, Hot Springs, June 1, 1955.

or complete occlusion of the internal carotid artery. The importance of this disorder was emphasized in 1899 by Gowers and in 1914 by Hunt. Egas Moniz and his collaborators, in 1937, were the first to describe cases of this condition diagnosed by arteriography. Its frequency is indicated by an incidence of 1 per cent in all arteriograms performed in Egas Moniz's clinic. Thrombosis of the internal carotid artery can occur from the second decade to the seventh; the highest incidence appears to be in the fifth and sixth decades. Etiologically, it is most often related to arteriosclerosis and occasionally to thromboangiitis obliterans. The two commonest sites of thrombosis are near the point of origin of the internal carotid artery and in the intracranial portion of this vessel close to its termination at the circle of Willis. Denny-Brown⁴ has pointed out that this disorder should be considered in patients with recurrent neurologic symptoms apparently related to vascular disease of the brain. Numbness of the face or extremities, weakness or paralysis of the face, arm or leg and aphasia persisting for a short time and followed by improvement, perhaps with complete remission, are characteristic symptoms. Blindness may or may not occur. Arterial pulsations in the neck may appear to be full and normal on both sides. Denny-Brown has suggested that many of the cases of transient neurologic symptoms attributed to spasm of cerebral vessels are due to insufficiency of the carotid or basilar artery. He has also called attention to the fact that recurrent symptoms referable to the nervous system can occur on the basis of partial occlusion of the basilar artery, especially in its lower third. Symptoms of basilar involvement include attacks of mental confusion, blindness or unconsciousness, with residual bulbar dysarthria.

Arteriography is the principal means of demonstrating thrombosis of the internal carotid artery. If cerebral vessels are viewed after the injection of the dye, normal or increased circulation in the external carotid branches may be seen, and the branches of the internal carotid artery are invisible. Occasionally, the lumen of the part of the artery that lies within the sinus, or beyond it, is seen to be narrowed, irregular and abnormally straight, and flow through the anterior and middle cerebral arteries is decreased or blocked. Sometimes, the stump of the internal carotid artery, about 2 cm. or less in length, may be seen in the film of the neck when the occlusion occurs close to the common carotid artery. Denny-Brown has also urged caution in the use of arteriography in elderly pa-

tients, because of the danger of producing thrombosis in extremely atheromatous vessels. He has described two clinical tests that may be of value in diagnosis of this disturbance. Observation of the fundus on the side of the suspected lesion while the opposite carotid artery is compressed or while light pressure on the globe of the eye is exerted with the finger discloses narrowing of retinal vessels, if they derive their circulation from the opposite carotid artery. He states that these tests are positive in only about half the cases, probably because of the presence of external carotid collaterals. Compression of the carotid artery on the side of the symptoms will also reproduce the symptoms in about half the cases. Denny-Brown regards a history of repeated episodes of paralysis in the same limb as the most characteristic feature of the syndrome.

Progress in vascular surgery has been such as to make it feasible to remove the partially occluded region of the internal carotid and anastomose the ends of the carotid or insert an arterial transplant or plastic tube in place of the diseased section of the artery. This possibility is now being considered in a number of neurosurgical clinics.

Hepatolenticular Degeneration

Hepatolenticular degeneration (Wilson's Disease) is a familial disorder characterized by signs and symptoms of disturbed function of the extrapyramidal system and accompanied by cirrhosis of the liver. In many patients there is present a peculiar greenish brown pigmentation of the cornea near the scleral juncture, the Kayser-Fleischer ring. The neurological manifestations are varied, but usually they consist of tremors and rigidity. The tremor may be of the wing beating type. This is a peculiar abnormal movement of the upper extremities, usually absent when the arms are at rest but developing after a quiet period when the arms are held extended, and consisting in an up and down movement of the hand or of the entire arm. In some patients there is an intention tremor on finger to nose movements, and in others there is a parkinsonian type of tremor. The rigidities are of the cog-wheel or lead pipe varieties. The course of the disease has been invariably downhill, terminating in death of the patient within a few months or years.

The presence of two metabolic errors in hepatolenticular degeneration has been firmly established. In the first place, Cumings⁵ has fully confirmed earlier reports describing abnormal accumulations of tissue copper and an excessive excretion of copper in the urine of patients with

this disease. Secondly, increased urinary excretion of amino acids, in the absence of hepatic failure, has been demonstrated in this disorder by Uzman and Denny-Brown.⁶ A rise in urinary excretion of the ten "essential" amino acids and also of the "non-essential" acids, glycine and alanine, has been shown to occur in the absence of an elevated serum amino nitrogen. It has been suggested that the abnormality of amino acid excretion is secondary to a failure of reabsorption of the amino acids by the renal tubules.

Serum copper values have been described as abnormally high in cases reported by Glazebrook,⁷ although not all patients demonstrated an elevation of serum copper. Serum copper is almost entirely in the form of a metalloprotein complex, which Holmberg and Laurell have shown to be a single pure protein, called by them caeruloplasmin. This protein is blue globulin of molecular weight of about 151,000, each molecule containing 8 atoms of copper. Electrophoretic analysis has shown that it is in alpha globulin. Scheinberg and Gitlin⁸ have observed that patients with hepatolenticular degeneration have much less caeruloplasmin in their serum than normal subjects, despite the fact that their serum levels may be either higher or lower than normal; the caeruloplasmin content of the serum of patients with this disorder is consistently too low to account for the total amount of copper present in the serum.

It has been suggested by Himsworth⁹ and by Uzman and Hood¹⁰ that the cirrhosis observed in hepatolenticular degeneration is the direct consequence of the chronic loss of amino acids, in accordance with the observation of the high incidence of hepatic involvement by itself in families in which one or more members are affected, as well as in the Fanconi syndrome, which is also characterized by a generalized aminoaciduria.

Denny-Brown and Porter¹¹ and Cumings,¹² as well as others, have reported clinical improvement after the administration of BAL. Varying dosage schedules have been employed, and courses of therapy have usually been repeated. Fading of the Kayser-Fleischer ring has also been reported by Denny-Brown. He suggests that the development of severe forms of the disease may be prevented by detection early in its course and treatment with BAL at this stage. Uzman and Hood¹⁰ report that 5 of the asymptomatic members of a family in which 4 siblings died as a result of hepatolenticular degeneration had persistent amino acid in the urine. With laboratory procedures capable of demonstrating the biochemical defects characteristic of this disease, de-

spite the absence of overt clinical symptoms, and with a form of therapy that holds out hopes of forestalling the development of serious symptoms, a more optimistic approach may be taken to this hitherto untreatable neurologic disorder.

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A NEW PAMPHLET:

"Free Health Care For Everyone?"

The Chamber of Commerce of the United States has just put out an interesting and informative little booklet entitled "Free Health Care For Everyone?" Single copies are available on request, while quantities of 100 cost \$4.50. Orders can be placed with the Economic Research Department, Chamber of Commerce of the United States, Washington 6, D. C.

An introduction states that "the purpose of the leaflet is to pull together and boil down interesting and useful information about problems involving our health—an important economic subject." The questions and answers are in the form of a conversation between an intelligent, serious-minded American citizen and a specialist on health problems. "Their conversation," the booklet says, "describes many different approaches to the big problem of providing better health care for all."

X-RAY SIGNS OF SMALL BOWEL DYSFUNCTION*

FRED JENNER HODGES, M.D.**

The upper gastro-intestinal tract, pharynx to jejunum, and the colon, anal orifice to terminal ileum, can be examined quickly and in great detail by commonly employed X-ray technics. This is a fortunate state of affairs because the most common organic alimentary disorders are to be found in these segments. Being relatively inaccessible to exacting visual scrutiny, the jejunum and the ileum, some twenty feet in overall length, have received far less attention by radiologists than is warranted by their great importance to the digestive process. To be sure, methods for investigating the small bowel have been devised^{1 2 3} and employed, but in general they are infrequently applied with the result that the sum total of exact knowledge concerning detailed structural and complex functional characteristics of the small intestine is meager and sketchy.

The best that radiologic investigation has thus far been able to achieve in evaluating the amazingly intricate performance of the small intestine has been to detect a relatively few deviations from expected normal appearances. Little or nothing has been offered by radiologists to gauge the great and important exchanges of fluids between gut wall and lumen, or the reduction of ingested foods to basic compounds which can be assimilated. It is possible to form some opinion regarding the ultimate effectiveness of propulsive activities and the ability of the muscle coats to contract and relax in response to normal and artificial stimuli.

Surprisingly little is known about the nervous mechanism which regulates secretory and muscular activities of the small bowel. In general it is held that the parasympathetic fibers derived from the vagus furnish motor stimuli, while the sympathetics from the splanchnics are inhibitors. The effects of these two systems are reversed in the case of the sphincters. Peristaltic contractions can be initiated locally by reflexes within the plexuses of Auerbach and Meissner situated between the muscle coats and in the submucosa respectively. By the employment of drugs which act upon sympathetic and parasympathetic ganglia, or directly upon smooth muscle, alterations in small bowel behavior observable by radiologic methods can be produced.⁴

One clinical situation which is characterized by profound and readily demonstrable alteration

of motor and secretory activities of the small intestine is ileus, whether mechanical or adynamic.⁵ Whether autonomic control is lost through chemical or bacterial causes, or by blockage of the gut lumen, ileus promptly makes itself known by the accumulation of gas followed by fluid and progressive, often profound distention. These obvious and startling findings may be of major importance in the apprehension of hitherto unsuspected organic lesions and the wisdom of exploiting every possible radiologic sign of intra-abdominal abnormality, including functional changes, in order to recognize organic bowel lesions is well established.⁶

It is sometimes difficult to differentiate with reliable accuracy between small bowel dysfunction which reflects organic disease and that which has no readily recognizable anatomical basis. On other occasions the segmental limitation of abnormal dimensions or contour of gut at once suggests that a localized organic lesion is the underlying cause.

The radiologic signs which are produced by misbehavior of the small intestine are not numerous or complex. (1) The rate at which chyme is propagated through the small bowel is reasonably constant and major deviations from the normal "transit time" from pylorus to ileocecal junction must be considered as evidence of faulty motor function. (2) The pattern imparted by the mucosal lining to the barium column should be distinctively faithful and delicate, making due allowance for modifications related to transient muscular contractions. When the luminal barium cast shows unusually coarse mucosal markings, or when the pattern is lost, faulty function of the muscularis mucosae may be postulated. (3) Reasonably wide variations in lumen width are to be expected along the course of the small bowel. Such changes can often be observed during fluoroscopic examination. Profound or persistent narrowing or distention, whether widespread or segmental, are not normal and often represent disturbances of autonomic innervation.

Numerous additional presumptive evidences of disturbed small intestinal function have been discussed in radiologic literature under somewhat ambiguous descriptive terms such as: "Puddling," "String Sign," "Segmentation," and the most ephemeral of all, "Deficiency Pattern," all of which relate in one way or another to the basic appearances which have been cited. As

* Presented before the Arkansas Medical Society Meeting, Hot Springs, Arkansas, May 30, 1955.

** From the Department of Radiology, University of Michigan.

for "Deficiency Pattern," this glib term implies an understanding of the underlying cause which is seldom the case.

Faced with the necessity of searching for the cause of persistent gastro-intestinal symptoms, which cannot be explained upon the basis of demonstrable organic faults involving the esophagus, stomach, duodenum or colon, the internist or surgeon should ask his radiologic colleague to explore the small intestine. This may be done by inserting a tube past the pylorus, for a few inches into the duodenum, and delivering barium sulphate suspension directly. By this technic, known as a small bowel enema, the entire length of the small intestine can be filled in a matter of minutes quickly bringing to light lesions which interfere with the adequacy of lumen width. Another method consists of feeding by mouth as in gastro-intestinal examination, and then observing the patient fluoroscopically and exposing films at 15 or 30-minute intervals until the opaque material has reached the ileocecal junction. Both procedures are time consuming and in most X-ray departments their use would seriously disrupt the routine of daily practice if detailed small bowel examinations were to be requested in great numbers of patients. It is possible by a relatively simple and rapidly applied procedure to learn a great deal about the small bowel, enough to determine in which patients more elaborate methods are indicated. This consists of obtaining a large survey film of the entire abdomen immediately following barium ingestion and standard fluoroscopic observation of esophagus, stomach and duodenum, and following this with similar film examinations at two and one-half and at five hours. In the case of normal individuals, administered barium will have cleared the stomach or nearly so at the two and one-half hour interval and some of the jejunum and most of the ileum will be filled. Five hours after feeding one may expect that most of the barium will be found in the right colon, with some residual filling of the terminal twelve to eighteen inches of ileum. While there are fairly broad variations from this time table of events, gross delays in transit time are readily apparent. From the three films described it is possible to determine whether major abnormalities in the form of dilatation or narrowing of the gut or profound alterations of mucosal pattern exist. Most organic small bowel lesions can be apprehended in this way even though more detailed examination may then be indicated. Unfortunately not all lesions responsible for obscure intestinal bleeding can be discovered by this technic or by any other device for that matter.

Use of interval filming in patients with non-descript symptoms of vague abdominal distress, sensation of bloating or "heaviness," mild diarrhea alternating with constipation, nausea and occasional vomiting will sometimes yield startling evidence of faulty small bowel function in the absence of any recognizable organic lesion. Diabetic patients with clinical signs of peripheral neuropathy often show comparable derangement of gastro-enteric nervous mechanisms. When present, diabetic alimentary neuropathy is graphically shown by interval filming. Correction of uncontrolled hyperglycemia may cause a dramatic return to normal small bowel behavior.

Indistinguishable evidences of small bowel dysfunction are encountered in the case of patients with pernicious anemia who present neurological symptoms and here too normal function may return with effective correction of the blood picture. The little understood and uncommonly encountered situation known as general autonomic imbalance is associated with clear cut signs related to the small bowel, and it would be difficult to substantiate the diagnosis of sprue without the characteristic X-ray signs.

Greatly prolonged transit time or unusually rapid advance with paradoxical residual filling of long reaches of small bowel are strong indications of autonomic disturbance. After effective vagotomy and following splachnicectomy for the amelioration of hypertension abnormal radiologic findings can be observed. Actual histologic evidences of nerve degeneration have been obtained in autopsy material from patients with profound signs of small bowel dysfunction during life. The fact that in some instances the radiologic signs of faulty autonomic control of the bowel have been observed to disappear indicates that purely functional disturbances do occur and may be reversible.

Gastro-intestinal X-ray examinations should include the full length of the small bowel if the symptoms and signs of alimentary disease cannot be adequately explained by the demonstration of lesions in the readily accessible portions of the digestive tract. Altered physiologic behavior, as well as abnormal structural features, may be utilized in the detection of localized organic lesions. Over and beyond structural abnormalities, purely functional derangements of clinical significance can be recognized by simple interval filming during the transit of barium through the small bowel. This device is of great service in the selection of patients for more elaborate and time consuming diagnostic procedures.

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OPHTHALMOLOGY IN PUBLIC WELFARE

K. W. COSGROVE, M.D.*

The Arkansas Department of Public Welfare was formed to take over the care of the needy from the various Federal agencies (ERC, ERA, SCD, etc.). Starting in 1935, small financial grants were given to needy blind. They were certified as blind by any physician. Late in 1937, ophthalmological examinations were required by the Social Security Board to obtain Federal matching funds for Aid to Blind payments. The report of examination had to be reviewed and certified by a Supervising Ophthalmologist who must be a licentiate of the American Board of Ophthalmology. In 1951, the U. S. Congress passed a bill instructing the states to accept eye examinations made by either ophthalmologists or optometrists in determining eligibility for Blind Assistance.

January 1, 1955, there were 1,942 persons receiving Aid to Blind assistance in Arkansas. Thirty-six (36) of these had been examined by an optometrist only. Two of them were bedfast and the Supervising Ophthalmologist accepted the reports made by the family physician. The remainder—1,904—were examined by ophthalmologists.

Many other services over and beyond financial aid have been initiated by the Welfare Department. These services include a loan to start the Lighthouse for the Blind (a private institution), the Employment Service, Vending Stands, Talking Books and Home Teachers for the Blind were started and turned over to the Rehabilitation Department. The Welfare Department has cooperated with the State Committee for Prevention of Blindness to start a Blind Register.

When in August of 1939, the State Board of Health could not finance a Trachoma Control Program, the Welfare Department paid the expenses of clinics which were held throughout the

State. A full-time clinician and nurse were employed for that service, until the work was taken over by the State Board of Health in July, 1940. The Trachoma Service examined over 20,000 a year. Approximately 8,000 cases of Trachoma were diagnosed and treated. The Service was discontinued by the State Board of Health in 1952 because very few new cases were being seen and funds were very low. It may be necessary for the Welfare Department again to finance a re-check of the Trachoma belt to determine if the disease has really been controlled.

Within the Welfare Department, ophthalmological services are given in several Divisions. All report forms are reviewed by the Supervising Ophthalmologist, and cases are referred to the proper divisions. Strabismus and ptosis cases are cared for by the Crippled Children's Division. The Remedial Eye Service was started in 1940, but was not officially functioning until 1942. The policies and methods of operation were set up by an Advisory Committee nominated from the EENT Section of the Arkansas Medical Society and appointed by the Governor. Except in cases of emergency, a person needing an eye examination and possibly treatment or surgery applies for this at his County Welfare Department, where he is shown a list of examiners. He makes his choice and is sent to the examiner with forms for the examination. The examiner completes the forms and returns them to the County Welfare Department. Copies are sent to the State Office, Remedial Eye Service, where the Supervising Ophthalmologist reviews the report and in turn lets the County Department know what further forms should be sent to the State Office for the patient in order that authorization may be sent for the surgery or treatment (if one or the other is needed). The patient signs a consent-for-surgery form, if surgery is to be done, and the County Department sends a form stating the financial circumstances of the patient are such

* Chairman's Address, EENT Section, Arkansas Medical Society, May 31, 1955.

that he cannot afford the necessary eye care from his own resources.

The State Office's Remedial Eye Service does all the authorizing of hospitalization and surgery for cases handled through that service, as well as authorizing treatment and glasses if the latter is provided.

In cases of emergency, if the patient has not been sent for the examination to the doctor by the County Welfare Department, the doctor contacts either the County Welfare Department or the Remedial Eye Service directly to clear the case for immediate hospitalization and surgery if the doctor feels the patient is not financially able to afford it himself.

A detailed report of the number and types of services given through Remedial Eye Service during the past six years is presented in Table I. There has been an increase in patients during the past three years. This is due to a great extent to emphasis being placed on glaucoma . . . miotics are bought for the patients and necessary observation stressed . . . as well as surgery provided if needed.

During the clinic years, the Remedial Eye Service worked with the State Health Trachoma Service in correction of entropion and other lid deformities. There were 1,193 lid operations done either in the field clinics or hospitals.

The benefits derived from the Remedial Eye Service since its beginning in 1940 cannot be valued in dollars and cents alone. There is no unit of measurement for the value of the return of vision or prevention of darkness. Some indication of the results can be seen in the reduction of the number of persons receiving blind assistance because of cataracts. In 1941, there were 20.1 per cent of those receiving Blind Aid that were cataract cases. In 1948, there were 18.1 per cent, and in January, 1955, there were only 9.6 per cent. Some of this reduction, no doubt, is the result of education. In 1948, there were 127 (or 47%) of the 288 cataract-blind that refused surgery, and in 1954, only 57 (or 30%) of 190 clients refused.

A study has been made of the Aid to Blind recipients. Race, sex, age at onset, visual acuity, etiology and site of eye lesion have all been recorded on IBM cards, along with other information. A complete report will be made of this at a later date. The complete study would be too lengthy for this paper. Table II shows the percentage of blindness by etiology in 1955-1948-1941 as determined by this study. The figures are similar to the national percentages estimated

in 1950 by the National Society for Prevention of Blindness in their released report. The Trachoma and Syphilis rates are higher in Arkansas. Trachoma, now 12% in Arkansas, is only 2% in the nation as a whole. Syphilis nationally causes blindness in 5.8%, and in Arkansas 7.9%. There has been a reduction in both of these diseases since 1941. It will also be noticed that there has been a decided reduction in the percentage blinded by injury, and there have been relative increases in blindness from glaucoma and pre-natal abnormalities.

TABLE I
Remedial Eye Service—1949-1954

	1949	1950	1951	1952	1953	1954	Totals
Cataract Surgery	166	181	187	157	186	213	1,090
Glaucoma							
Surgery	24	29	39	32	33	25	182
Pterygium							
Surgery	57	34	44	28	32	36	231
Enucleation	33	35	31	31	26	40	196
Injury Repairs	12	9	9	15	12	13	70
Lid Surgery	27	14	25	19	20	25	130
Detached Retina							
Surgery	1	1	4	5	3	5	19
Other Surgery.....	16	13	9	10	11	11	70
Total Surgery.....	336	316	348	297	323	368	1,988
Treatment Cases	23	11	28	84	117	276	539
Refraction and							
Glasses	456	483	346	154	155	400	1,994
TOTALS.....	815	810	722	535	595	1,044	4,521

TABLE II
Etiology of Blindness
Aid to Blind Cases—State of Arkansas

Etiology	Number 1955	Percent 1955	Percent 1948	Percent 1941
Acute Infections	155	7.9	5.7	7.8
Chronic & Focal				
Infections	141	7.3	3.5	4.1
Syphilis	154	7.9	8.6	12.1
Trachoma	234	12.0	13.1	15.2
Injuries	168	8.7	11.4	14.8
Poisonings	3	0.15	0.3	0.5
Neoplasms	1	0.05	0.3	0.1
General Diseases ..	177	9.2	3.7	3.5
Congenital	349	17.9	8.3	7.2
Glaucoma	299	15.4	12.9	11.6
Cataract	190	9.6	18.1	20.1
Others, Unknown ..	71	3.9	14.1	3.0

There have been 16,306 persons given one or more eye examinations through the Welfare Department since 1937. Both eyes were blind in 7,463 of these patients (or 45%); and one eye was blind in 4,373 patients (or 26.7%). There were 1,188 (7.3%) persons with glaucoma. 51 of these latter were juvenile glaucoma cases, and 37 secondary to injury. Glaucoma was the cause of blindness in 10% of blindness in both eyes, and 7.5% of blindness in one eye.

The geographical distribution of blindness due to Trachoma, Glaucoma and Syphilis is interesting. The percentage of blindness from Trachoma is much greater in the Northern and Western parts of the State; and from Glaucoma and Syphilis in the Southern and Eastern parts. Climatic differences and varying terrain are not the causes of this difference. The percentage of Negro population corresponds to the prevalence of the diseases. The Northwestern 28 counties have 1.9% Negro population, and the Southeastern 28 counties have 41.9%. In this series of cases, Trachoma is 100% in the White race. Blindness from glaucoma per 100,000 population is 8.7 in the White and 30.6 in the Negro. Syphilis is similar with 1.3 per 100,000 population in the White and 30.6 in the Negro.

It would seem to be the logical conclusion that the racial distribution is responsible for the varying prevalence of these diseases.

TABLE III
Geographic Distribution of Trachoma, Glaucoma, and Syphilis in Arkansas' Aid to Blind Recipients

	State of Arkansas	N & W Area	Central Area	S & E Area
Aid to Blind				
Recipients	1,942	622	591	729
Trachoma Blind.....	234	156	57	21
Glaucoma Blind	299	63	40	196
Syphilis Blind	154	9	45	100
Percentage				
Trachoma	12%	25%	9.6%	2.8%
Percentage				
Glaucoma	15.4%	10.1%	6.7%	26.9%
Percentage				
Syphilis	7.9%	1.3%	7.6%	13.7%
Total Population*	1,909,511	564,501	576,618	766,394
Percentage Negro	22.3%	1.9%	18.8%	41.5%

* 1950 Census.

In Summary

Social Service to restore sight, usefulness, and self-respect—rather than the dole—has been the aim of the Arkansas Department of Public Welfare. All agencies in the State serving the visually handicapped have either been initiated by or assisted by this Department.

A detailed study of causes of blindness among the Aid to Blind recipients has been made. Some of the statistics quoted in this paper show the averages for Arkansas are similar to estimates for the entire nation. Efforts to prevent blindness must be directed to those causes that we can influence.

Education of the public is most important. Injuries and infections as causes of blindness can be reduced by knowledge of the dangers. Above

all, the control of glaucoma requires education not only of the public, but also of the general practitioner and the optometrist. They see many more patients than the ophthalmologists. Early diagnosis and treatment must be explained and stressed.

The best results in aiding our visually handicapped can only come through close cooperation between the ophthalmologist and the social worker.

FELLOWSHIPS FOR BASIC RESEARCH IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering the following research fellowships in the basic sciences related to arthritis:

1. Predoctoral fellowships ranging from \$1,500 to \$3,000 per annum, depending on the family responsibilities of the fellow, tenable for 1 year with prospect of renewal.
2. Postdoctoral fellowships ranging from \$4,000 to \$6,000 per annum, depending on family responsibilities, tenable for 1 year with prospect of renewal.
3. Senior fellowships for more experienced investigators will carry an award of \$6,000 to \$7,500 per annum and are tenable for 5 years.

The deadline for applications is October 15, 1955. Applications will be reviewed and awards made in January, 1956.

Address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

SKIN PROBLEMS

The Institute of Industrial Health of the University of Cincinnati announces that the course of instruction in **Occupational Skin Problems** will be given during the week of October 10-14, 1955. It will be presented by the Department of Preventive Medicine and Industrial Health, University of Cincinnati, in collaboration with the Occupational Health Program of the United States Public Health Service, and the Department of Dermatology and Syphilology of the University of Cincinnati. The objective of this course is to give physicians a greater understanding of cutaneous problems of occupational origin.

Physicians interested in attending the course should write for an application blank to Secretary, Institute of Industrial Health, Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 19, Ohio. Apply early as attendance will be limited.

— ★ Editorial ★ —

Contributions to the American Medical Foundation are due at any time, and members are urged to set aside an annual gift, to show that physicians are aware of their responsibilities. President Eisenhower has indicated that he will push legislation for medical schools' support. This means Federal domination of yet another segment of our society, and prompt and generous support of our medical schools by gifts, and by local support, can keep us from losing the independence, and freedom of the schools, and of their control by Washington. A few educators in our own state are asking for Federal money without seeming to realize that higher taxes will be demanded, and that only a small percentage of a tax dollar ever reaches its ultimate destination, when it goes via Washington.

The University of Arkansas is the beneficiary of much money from A.M.E.F. We cannot afford to fail in our support of a program where 100% of the dollar you give goes to its intended use. To ask the Federal government to further regulate our institutions, and our lives, and to take more and more of our income from us in taxes, is short sighted. We are not sure that our educators who ask Federal help (and control) are looking beyond their noses.

The average physician will get a lot more pleasure out of writing a check to a worthy medical cause than he will from writing a check to the Collector of Internal Revenue!

Contributions to the American Medical Education Foundation from the State of Arkansas During the Month of July, 1955:

Woman's Auxiliary to the Arkansas Medical Society.

Troy M. Price, Strong.

DR. RILEY RETIRES

For something like three decades the name of J. D. Riley has been synonymous with the treatment of tuberculosis in Arkansas. It is not without some feeling, that the physicians of the state learned the news of his recent retirement.

The early years of the State Sanatorium, near Booneville, were full of struggle for survival, for funds, for physicians, and for nurses. Dr. Riley came to the situation—a "cure" himself, and brought his plans and dreams of a great sanatorium. To a large extent, the growth, modern-

ization, and sustenance of the sanatorium can be credited to him.

New buildings were added, equipment and therapy were kept modernized. A herd of milk cows was built up. Modern farming usages were employed. The State Sanatorium became the Tuberculosis Center of Arkansas, both for diagnosis and treatment.

Dr. Riley spent many hours pleading his patients' cause before the State Legislatures. He built up, and trained, many specialists in chest conditions, and in tuberculosis. He was the recipient of many honors, and occupied many important positions because of his work in Booneville.

The physicians of Arkansas and the Journal acknowledge the magnificent contributions that J. D. Riley has made to the profession, and to the State of Arkansas.

SOUTHERN MEETS IN HOUSTON

The Southern Medical Association will hold its 49th Annual Meeting in Houston, Texas, on November 14-17, 1955. More than 3,000 of the Association's 10,000 members are expected to attend the four-day meeting.

The Scientific Assembly of the Southern Medical Association is one of the nation's outstanding postgraduate events for practicing physicians. The intensive work of the Scientific Assembly will feature some 300 papers by outstanding researchers and practitioners in all of the major medical and surgical fields. The following Sections will hold from one to three sessions: Anesthesiology, General Practice, Gastroenterology, Medicine, Surgery, Neurology and Psychiatry, Pathology, Proctology, Urology, Gynecology, Obstetrics, Public Health, Industrial Medicine and Surgery, Pediatrics, Allergy, Radiology, Dermatology and Syphilology, Physical Medicine and Rehabilitation. Orthopedic and Traumatic Surgery, Ophthalmology and Otolaryngology. All of the scientific programs of the twenty Sections will be presented in the various meeting rooms of the fabulous Shamrock.

In addition to the twenty Sections of the Association, several other major specialty groups will meet conjointly. Among those planning programs in Houston are: American College of Chest Physicians—Southern Chapter, Association for Research in Ophthalmology, Southern Gynecological and Obstetrical Society, Women Phy-

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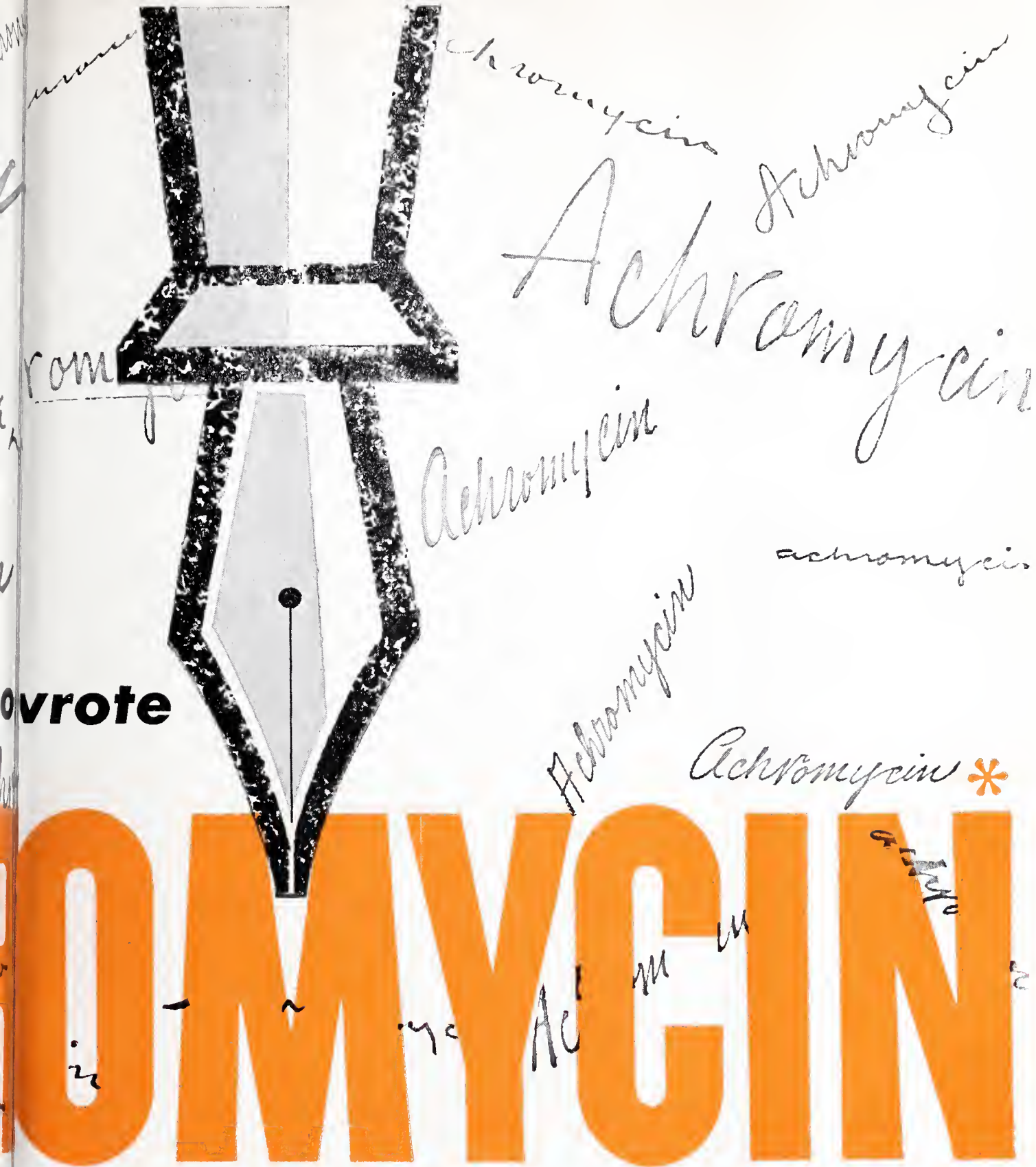
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infections including those caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa. Furthermore, it is a *quality* product; every gram is made under rigid control in Lederle's *own* laboratory.

ACHROMYCIN, a major therapeutic agent now...growing in stature each day!



sicians, and the Southern Society of Cancer Cytology.

More than 200 technical and scientific exhibits will be housed in the Exhibit Hall of The Shamrock—readily accessible to the meeting rooms.

The Association has a Housing Bureau, Box 1267, Houston, Texas, to which all requests for hotel accommodations should be addressed. A formal hotel reservation form appears in every current issue of the Southern Medical Journal and will also be attached to the Preliminary Program which will be mailed to 37,500 physicians in the South.

There will be two General Sessions of the membership. The Opening Assembly, open to the public, will be held in The Emerald Room of The Shamrock on Monday, November 14, at 10:30 a.m. President of the Association Robert L. Sanders, M.D., of Memphis, Tennessee, will deliver the annual Presidential Address. His subject will be "Values in the Practice of Medicine." Following Dr. Sanders, Dr. Francis P. Gaines, President of Washington and Lee University, special guest of the President, will speak on "The Range of Loyalty." Dr. Gaines is one of the South's outstanding educators and lecturers.

The second General Session will be held in The Emerald Room of The Shamrock on Wednesday evening at 7:00 p.m. This session, known as the Annual Dinner and President's Night, will be highlighted by the election of officers, the installation of W. Raymond McKenzie, M.D., of Baltimore, Maryland, the incoming President; the presentation of the Past President's medal to R. L. Sanders, M. D., the presentation of awards; and professional entertainment followed by the Annual Dance.

The 32nd Annual Golf Tournament will be held at the Lakeside Country Club on Tuesday and Wednesday, November 15-16. Three major trophies are to be awarded—The **Daily Oklahoman and Times** Cup, in play since 1938; The **Miami Daily News** Cup; and the **Dallas Morning News** Cup, in play since 1925.

The Woman's Auxiliary of the Association will also hold its Annual Session during the same dates with headquarters in the Rice Hotel. An unusual program of social events, entertainment, tours, and of course, necessary business, has been planned. Mrs. Louis K. Hundley, President, of Pine Bluff, Arkansas, will preside over the Sessions and will be succeeded by Mrs. John J. O'Connell, St. Louis, Missouri, at the close of the meeting.

Among the convention attractions of Houston are: the famed San Jacinto Monument, the battleship Texas which is moored permanently in the San Jacinto Battlegrounds, the \$100,000,000 Texas Medical Center and scores of cultural and civic attractions.

The official Post Convention Tour to Mexico City will leave Houston by air on Thursday afternoon for a ten-day tour of Mexico. The tour, arranged by the International Travel Service, Inc., of Chicago, will be personally escorted by Mr. Frank E. Smith, former Executive Director of the Blue Shield Commission. Tour information will be mailed to members and will appear in the Journal and Official Program.

The University of Tennessee College of Medicine will offer 12 postgraduate programs for physicians during 1955-1956, Wallace Mayton, director of the Postgraduate Department, announced recently.

Courses and the dates they will be offered are:

Office gynecology, Sept. 7, 8 and 9, 1955; radiology, Sept. 14, 15 and 16, 1955; clinical electrocardiography, Oct. 5, 6 and 7, 1955; prevention and management of cardiac arrest, Oct. 20 and 21, 1955; hematology, Feb. 28, 29 and March 1 and 2, 1956; diagnosis and management of peripheral vascular diseases, March 7, 8 and 9, 1956.

Pediatrics March 14, 15 and 16, 1956; gastroenterology, March 28, 29 and 30, 1956; fractures and dislocations, April 25, 26 and 27, 1956; dermatology, May 9, 10 and 11, 1956; cardiovascular diseases, May 23, 24 and 25, 1956; abdominal surgery, July 25, 26 and 27, 1956.

In addition three five-day diversified programs for general practitioners will be offered by three divisions of the college. The courses and the dates offered are:

Division of Medicine, Sept. 26-30, 1955; Division of Obstetrics and Gynecology, Oct. 24-28, 1955; and Division of Pediatrics, Nov. 7-11, 1955.

QUOTES:—

"A well-informed membership is imperative if we are to have unity and strength and warmth as an organization."

"Somehow, it seems to me, we doctors here in Cincinnati must find a political, sociologic, and economic nature which are of supreme importance for our welfare and that of our patients without sacrificing the excellence of our scientific programs."—Ernest B. Howard, Presidential Address at the Ohio State Medical Association, 1955.

CORRESPONDENCE

July 12, 1955

Paul C. Schaefer, Exec. Sec'y,
Arkansas Medical Society.

Dear Mr. Schaefer:

Thank you very much for sending a copy of the Arkansas Medical Society's resolution opposing federal aid to medical education which was adopted by your House of Delegates on June 1, 1955.

Permit us to congratulate most heartily the members of your Society on their forthright position against federal aid to medical profession or, in other words, federal control of medical schools and students.

We are happy to advise that the members of this Association are in complete accord with your position as expressed in the resolution.

If there is any way that AAPS or the writer can be of assistance to you and the members of the Arkansas Medical Society please advise, because we desire to help in any way we are able.

Sincerely,

Harry E. Northam,
Executive Secretary,
American Physicians &
Surgeons Association.

August 18, 1955

To the Editor:

Dear Sir:

Please express to members of the Arkansas Medical Society, and of the Arkansas Academy of General Practice, my appreciation for their many courtesies to me while I was attending their meetings, and a visitor in Arkansas during the past year. Their many kindnesses will be remembered for a long time.

Please add also my thanks to the several individual surgeons who so generously gave me of their surplus instruments to be used in our mission hospital here in Morelia. They can be assured that those instruments we use fill a great need, and those we can't use are sent on to other medical purposes, and are of great value.

Fraternally yours,

J. Hervey Ross, M.D.,
Director,
Presbyterian Mission Hospital.

Sanatorio La Luz
Morelia, Michoacan, Mexico.

THINGS TO COME:

ARKANSAS ACADEMY OF
GENERAL PRACTICE

October 5-6, 1955

Lafayette Hotel, Little Rock

SOUTHERN MEDICAL ASSOCIATION

Shamrock Hotel

November 14-17, 1955

Houston, Texas

ARKANSAS MEDICAL SOCIETY

April 23-25, 1956

Little Rock

AMERICAN MEDICAL ASSOCIATION

(Interim Session)

November 29th - December 2nd, 1955

Boston, Mass.

Arkansas

TRAVELING

And Clipping Bits Here and There

ON RETIREMENT

Forced retirement at age sixty-five seems arbitrary and unreasonable. Employed persons are much happier than idle ones and, as we have said, they continue to live longer. It is doubtful if the American economy can withstand indefinitely the impact of having all persons over sixty-five cease work and expect to receive pensions no matter where the money comes from. It is a most tragic waste to the national economic community to permit persons with long training in the various skills to become unproductive. Experience and wisdom are valuable assets not to be discarded lightly.

If retirement is mandatory on a basis of age alone, it is better to retire **to** another activity than to retire **from** all activities. Those who do the latter become our patients with problems that are not amenable to ordinary medical treatment. Physical and mental deterioration begins to take place. Dissolution sets in. Senescence becomes a reality.—Charles Sellers, in "Geriatrics and the General Practitioner."

"Desperate diseases, require desperate remedies."—English Proverb.

A SPECIALIST

A specialist is a man who does the easy thing the hard way and charges accordingly. Or . . . He is a man who knows how to do one thing so well that the people will not let him do anything else.

ANNOUNCEMENTS

Physicians interested in presenting a scientific exhibit at the Annual meeting of the Arkansas State Medical Society April 23 and 25 should write to:

Lawrence M. Zell,
937 Donaghey Building,
Little Rock.

OKLAHOMA CITY CLINICAL SOCIETY

The Oklahoma City Clinical Society will open its twenty-fifth annual four-day Conference on October 24, 1955.

As in former years, an outstanding program of postgraduate teaching has been arranged. This includes lectures and discussion by sixteen distinguished guest speakers selected from various medical and teaching centers throughout the nation, as well as many Oklahoma City teachers and physicians. Elmer Hess, Erie, Pennsylvania, will give an address at the opening banquet on October 24th. In addition to the general assemblies and panel discussions there will be daily luncheon round table question and answer sessions, and a clinical pathologic conference. The entertainment will include dinner meetings, the annual Clinic dinner dance and the stag smoker.

A cordial invitation is extended to all physicians who are members of their County Societies to attend this meeting from October 24th through October 28th at the Biltmore Hotel.

Richard V. Ebert, professor of medicine at the University of Arkansas Medical School, is one of the featured speakers.

EXHIBIT ON UTERINE CANCER TEST AVAILABLE

The importance of the cytologic test for uterine cancer as a diagnostic aid in routine office practice is explained for physicians in a new exhibit available to medical groups on loan from the National Cancer Institute of the Public Health Service, U. S. Department of Health, Education, and Welfare, Washington.

The exhibit was shown for the first time at the American Medical Association meeting at Atlan-

tic City, N. J., in June. It reports the results of the cytologic test as applied to 70,000 women in Memphis and Shelby County, Tennessee, under a project conducted by the National Cancer Institute with the cooperation of local medical and public health groups to demonstrate its value as a case-finding procedure in large populations.

The Memphis project produced a case-finding rate 40 times that previously observed in the community, and 88.3 per cent of the intraepithelial carcinomas of the cervix discovered were unsuspected.

One of the most important facts revealed by the Memphis data was that intraepithelial carcinoma, or preinvasive "carcinoma-in-situ" in the stage considered practically 100 percent curable, was found most often in women of the 30 to 35 age group. Invasive cancer, on the other hand, was found most often in the 50 to 55 age group.

In addition to presenting these data, the National Cancer Institute exhibit illustrates the aspiration method of taking a vaginal smear for cytologic examination. A folder explaining this procedure in detail, which is helpful in training nurses or medical technologists, is also available from the Institute.

EXHIBIT ON ALCOHOLISM

The startling fact that "one out of 16 adult men and women drinkers becomes an alcoholic" is borne out in a new medical exhibit on alcoholism currently in production by the A.M.A.'s Bureau of Exhibits. Unveiled at the association's annual meeting in June in Atlantic City, this exhibit discusses the etiology, diagnosis, and treatment of the disease, and shows the progressive stages from an occasional drinker to the alcoholic. Particularly stressed are the many procedures employed in treating acute alcoholic intoxication as well as chronic alcoholism, including total abstinence, hospitalization, restoration of fluid balance, and compensation for dietary deficiencies by prescribing high carbohydrate intake, vitamins, etc.

The exhibit, which is being prepared in cooperation with the Committee on Alcoholism of the A.M.A. Council on Mental Health, is now available for showings at state medical society meetings and allied professional gatherings.

CHAMBER OF COMMERCE ON VETERANS' MEDICAL CARE

Each year at the close of its annual meeting, the U. S. Chamber of Commerce puts in book form the chamber's policy declarations. These declarations show where the Chamber of Com-

merce of the United States stands on national issues.

The 184-page book sets forth the recommendations of the organized business movement for the solution of national problems.

Under the chapter heading, "Economic Security," the chamber set forth this policy declaration on medical care for veterans—the first it ever adopted on the subject:

"The federal government provides for the medical care for veterans through federally owned and operated hospitals and salaried physicians. The rapid expansion of the veteran population and the extent to which services are rendered to veterans with non-service-connected disabilities justify a searching re-evaluation of the entire program. A definition of 'beneficiary' that is just both to the veteran and to the nation as a whole is urgently needed."

National Agricultural Chemicals Association has a "Clinical Memoranda on Economic Poisons" available to any physician who practices in any rural area. The brochure is a compendium of information on chemicals used in agriculture, their uses, dangers, and antidotes, etc. For a free copy write National Agricultural Chemicals Association, 1045 19th St. N. W., Washington 6, D. C.

Obituary

JAMES ARTHUR SUMMERS, 74, died at his home on July 8, 1955.

Dr. Summers, a graduate of the University of Arkansas Medical School, was appointed health officer by former Pulaski County Judge R. A. ("Bob") Cook in 1933. Before taking the county post he was city health officer four years at North Little Rock, where he first practiced medicine.

He was a member of the Pulaski Heights Baptist Church, and a life member of the Pulaski County Medical Society, and the Arkansas Medical Society. Dr. Summers was a Mason and a member of the Little Rock Consistory, Scimitar Shrine, Chanters Club of the Shrine, and the Little Rock Civitan Club.

Survivors include his wife, Mrs. Ollie Merriam Summers; two sons, a brother, six grandchildren, and three great-grandchildren.

Funeral services were held at Pulaski Heights Baptist Church. Members of the Pulaski Medical Society were honorary pallbearers. Burial was at Roselawn Memorial Park.

WILLIAM B. GOULD, 82, died suddenly in his office August 2, 1955.

He was the oldest practicing physician in Southwest Arkansas, having been a practicing physician in Pike County for more than half a century.

In 1894, Dr. Gould first entered the practice of medicine at Bowen, Pike County, where he remained for two years before locating on Rock Creek, not far from where Glenwood now stands.

He was a charter member of the Glenwood Masonic Lodge and was honored as a 40-year member four years ago. He was also a member of the Odd Fellow Lodge. He served as postmaster of Glenwood from 1914 until 1922. He was a member of the Board of Stewards of the Methodist Church for 50 years. He was a member of the American Medical Association, Arkansas Medical Association and the Pike County Medical Society. He served as president of the Bank of Glenwood and the Glenwood board of education for a number of years.

He married Miss Nora Johnson, who survives, in 1899.

Two daughters, six grandchildren, and one great-grandson are other survivors.

It is with deep regret that we hear of the death of Mr. Jack L. Redheffer, Executive Director of the Arkansas Medical & Hospital Service, Inc.

He served through the formative years, and through the establishment of Blue Cross-Blue Shield in its new headquarters. He was an outstanding organizer and worker. He will be missed in medical circles.

The Journal extends its sympathy to his bereaved.

The Council on Postgraduate Medical Education of the American College of Chest Physicians will sponsor the following postgraduate courses on diseases of the chest this fall:

10th Annual Postgraduate Course, Hotel Knickerbocker, Chicago, Illinois, October 3-7, 1955.

8th Annual Postgraduate Course, Park-Sheraton Hotel, New York City, November 14-18, 1955.

Our postgraduate courses endeavor to bring physicians up to date on recent advances in the diagnosis and treatment of heart and lung disease. Tuition is \$75 for each course which includes round table luncheons.

Write the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

SARCOIDOSIS

By HAROLD L. ISRAEL, M.D., and MAURICE SOMES, M.D.

NTA Bulletin, April, 1955

Sarcoidosis, although not simply defined or described, resembles tuberculosis more than any other familiar disorder. However, there are important differences which distinguish the two diseases.

The epithelioid cell collections characterizing sarcoidosis take the form of tubercles or granulomas which may infiltrate the lymph nodes, lungs, skin, eyes, bones, liver, spleen, salivary glands, and occasionally the heart, kidneys and nervous system. Sarcoid tissue does not produce toxemia as do most infections and neoplasms; the replacement of normal tissue by myriads of sarcoid tubercles mechanically impairs the function of the involved organ.

Although Boeck first described the sarcoid lesion in 1887, it was many years before the disease was recognized as a systemic one which might involve any organ of the body. The earliest report of pulmonary sarcoidosis in the **American Review of Tuberculosis** appeared in 1933, but it was not until 1937 that Pinner's description acquainted most chest physicians with this disease. Since then, many reports on sarcoidosis have appeared. No longer a rarity, sarcoidosis is now one of the diseases most commonly considered in the diagnosis of chronic pulmonary disorders.

It had long been thought that almost all adults were tuberculin reactors. Recognition of the fallacy of this belief, and wider application of the tuberculin test, revealed that many patients with roentgenological and histological findings resembling tuberculosis had negative tuberculin tests. This finding, characteristic of sarcoidosis, led to studies which established a diagnosis of sarcoidosis in many cases.

Widespread X-ray surveys have led to the detection of many patients with diffuse pulmonary infiltrations or much enlarged lymph nodes. Often the chest X-ray appearance is alarming, and on examination one is struck by the patient's relatively healthy condition. Although many

times the disability is not proportional to the severity of the roentgenological changes, one must not be misled into thinking that sarcoidosis does not impair health.

Actually, it is uncommon to encounter a patient with this disease who is truly asymptomatic, who has not experienced fatigue and weight loss. Other symptoms depend upon the organs involved; examples are the shortness of breath and cough resulting from extensive pulmonary infiltration, the blurring of vision and even blindness resulting from ocular lesions, and the azotemia which may result from replacement of kidney tissue. Laboratory studies are helpful in directing attention to sarcoidosis. Patients with sarcoidosis as a rule fail to react to second-strength tuberculin, or react weakly. In two thirds of patients an increase in serum globulin concentration occurs.

A diagnosis of sarcoidosis can be made with confidence in the patient with characteristic organ involvement, negative tuberculin test, elevated serum globulin, and typical epithelioid tubercles in a specimen obtained by biopsy. Pathological study of a biopsy specimen alone cannot "prove" the diagnosis of sarcoidosis. Other diseases, notably tuberculosis, beryllium granulomatosis, and histoplasmosis may reveal a similar histological appearance. In some instances exhaustive study to exclude these diseases is required before the diagnosis of sarcoidosis can be established.

Cutaneous lesions or enlarged lymph nodes suitable for biopsy may not be available. New methods of securing tissue for histological study have been developed; scalenus fat pad and intercostal pulmonary biopsies as well as needle aspiration biopsy of the liver have proven of value in the diagnosis of sarcoidosis. The specificity of the Kveim reaction has not yet been established, and should not be relied upon in clinical practice.

The Scandinavian use of the term "benign

lymph-ogranulomatosis" for this disease and some of the earlier studies have resulted in a falsely sanguine impression concerning the disease. It was considered at one time that, except for the risk of development of tuberculosis, sarcoidosis was almost invariably benign. In recent years tuberculosis has been an infrequent complication, but sarcoidosis has proven a more serious disorder than it originally appeared to be.

Sarcoidosis is fatal in approximately 10 per cent of cases; and many patients experience serious permanent impairment of function as the result of scarring. Approximately half of patients recover spontaneously. Accumulating evidence indicates that in many instances where recovery seems complete, careful roentgenological and physiological studies will reveal considerable residual fibrosis.

A variety of therapeutic agents has been tried in sarcoidosis, but consistent effects have been obtained only with cortisone and ACTH. Their use is recommended only for carefully studied patients with sarcoidosis who have ocular lesions, progressive pulmonary disease, or other disabling symptoms.

The nature of sarcoidosis and its cause have not been determined. It was once widely believed that sarcoidosis was an atypical form of tuberculosis, but few investigators accept this theory at present. Disbelief in a tuberculous etiology of sarcoidosis has been based largely on the rarity with which tubercle bacilli have been demonstrable in sarcoidosis, and pathological characteristics such as differences in frequency of parotid, ocular, cardiac, pleural, and peritoneal involvement in the two diseases. Recent experience indicates that tuberculosis supervenes in sarcoidosis much less often than when there was greater exposure to tuberculous infection.

Certain epidemiological peculiarities of sarcoidosis have been investigated for possible clues to its etiology. A majority of the patients reported in this country have been Negroes. Epidemiological analysis of data from the armed forces, however, indicated that sarcoidosis was more frequent in both whites and Negroes born in the southeastern states, particularly in the rural areas. Sarcoidosis is frequent in northern Europe and infrequent in South America. These remarkable geographic vagaries would appear an important clue in the search for the cause or causes of sarcoidosis. They suggest either an infectious agent prevalent in certain soils or some constitutional or environmental influence in childhood which later results in an altered response to irritants or infection.

Although histoplasmosis and beryllium granulomatosis may stimulate sarcoidosis, it has been shown that these diseases are not factors concerned in its causation. Attempts to demonstrate other fungi, or viruses, have likewise been unsuccessful. It has been suggested that sarcoidosis be classified among the collagen disorders, diseases which appear to represent hypersensitivity reactions. At present it must be concluded that the cause and nature of sarcoidosis are unknown.

Although a relatively uncommon disorder, sarcoidosis has attracted an extraordinary degree of medical interest, inspired to some extent by the obscurity which surrounds the etiology and nature of the disease. Of more importance, however, is the fact that sarcoidosis is an example of poorly understood granulomatous diseases which are more often encountered, as tuberculosis and other respiratory bacterial infections decline in frequency.

Discovery of the causation of sarcoidosis might well cast light on the nature of these diseases. Possibly due to infection, to chemical irritants, to constitutional abnormalities, or to hypersensitivity, sarcoidosis and the other granulomatous diseases may prove to have a hitherto unrecognized type of genesis.

PERSONALS AND NEWS ITEMS

S. F. Dozier, Marianna, is president of the Chamber of Commerce in that town. Their prime objective for this year is to promote a 25-bed hospital for Marianna. The Journal believes that taking and showing leadership in civic affairs is part of the duty of all physicians and congratulates Dr. Dozier on his activities. He has been an officer in the Arkansas Medical Society, and in the Mid-South Postgraduate Assembly in Memphis, as well as in his County Society.

John W. Cole, Malvern, is a newly appointed member of the Board of Trustees of the Hot Springs County Memorial Hospital.

Garland D. Murphy, Jr., El Dorado, was elected to the Arkansas post on the American Legion's National Executive Committee at the July meeting in Little Rock.

The man and wife team of physicians, Frank and Mary Dulaney have opened offices in the Farmers Bank Building in Hamburg, but expect to move to the Hamburg Clinic when that building is completed. Both are graduates of the University of Arkansas.

James D. Grable opened a new clinic and office building in Des Arc in July.

H. B. Thorn, Jr., a native of Harrisburg, opened offices in Benton in July for a general practice.

James S. Dinning, Department of Biochemistry, University of Arkansas Medical School, has been awarded \$7,875.00 from the Lederle Laboratories Division, American Cyanamide Company, for research work in his department, for the next three years.

J. D. Riley, Booneville, has retired from active service at the Arkansas State Sanatorium, and has been named Emeritus Superintendent there. He leaves after many years of devoted and meritorious service to his state, and his profession. New Medical Director is C. A. Henry, who has been chief of staff for more than 10 years.

William I. Porter, Class of '44 of the University of Arkansas Medical School, has returned to private practice, and associated with Watson and Adametz in Little Rock.

W. B. Harrell, Texarkana, has an article entitled "The General Practitioner in the Clinic Structure" in the July Bulletin of the American Association of Medical Clinics.

Jack Q. Cash, a native of Monticello, has opened a clinic in Corning. He will do a general practice.

Ruth H. Junkin, Little Rock, has joined the Medical Service of the Veteran's Hospital in North Little Rock.

W. T. Holman has reopened his office in Van Buren after an absence of several months working in the State Sanatorium at Mt. Vernon, Missouri.

Grier D. Warren opened an office in Rogers at 224 North Second St. for a general practice on July 15. He is a native Arkansan, and has completed two years of residency in Little Rock.

Barton A. Rhinehart, Little Rock, walked away from a crash at Brinkley, July 7, when his Piper nosed over on the runway.

Paul Schaefer, Ft. Smith, executive secretary of the Arkansas Medical Society, addressed the El Dorado Kiwanis Club on July 6.

W. J. James, Clarksville, who has just completed a year's residency at the University Medical Center, reports to Roswell, New Mexico, for assignment in the Air Force in August.

Harold Hyder, Russellville, will be associated with the Mobley Clinic after October 1. He is a native of Russellville, and has spent the last year in Crawford W. Long Memorial Hospital in Atlanta.

Jerome Levy and Joe Norton, Little Rock, were sent by Pulaski County Medical Society to the A.M.A. Public Relations Committee Meeting in Chicago, August 31 and September 1st.

Walter A. Brooks, Russellville, has moved from his home to Quanah, Texas, where he will engage in a private practice.

Roy I. Millard, Russellville, attended a three-day post-graduate program on emergency surgery given by the University of Tennessee in Memphis during July.

William H. Morse, Blytheville, has opened an office for the practice of Urology in Memphis.

E. D. McKnight, Brinkley, veteran member of the State Board of Health, was reappointed to his position by Governor Orval Faubus, his new term to end December 31, 1958. Dr. McKnight at that time will have completed 29 years of service on that Board.

Joe Hutchinson has completed a year's work in Hillcrest Hospital, Tulsa, and opened an office in Gravette.

L. G. Stuckey moved to Little Rock in July and opened offices, limiting his practice to plastic surgery.

G. A. Sexton has recently opened an office in Trumann where he is an associate and ex-classmate of Floyd Smith, Jr.

Julian Fairley opened his practice in Luxora on July 15, using the clinic built 2 years ago by the Luxora Clinic Corporation.

Gordon P. Oates, Little Rock, announces the re-opening of his office following his release from a tour of duty with the Armed Forces.

President L. H. McDaniel, Tyronza, addressed the West Memphis Rotary Club August 1st.

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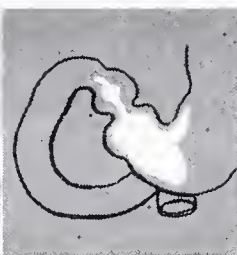
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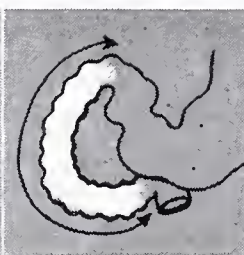
TYPES OF MOVEMENT WITHIN THE BOWEL



Food Breakdown



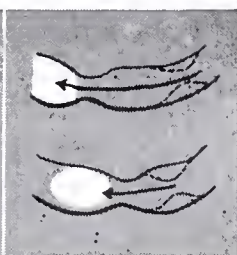
Pyloric Dilation



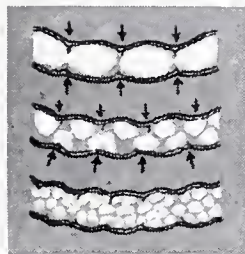
Duodenal Churning



Spiral Propulsion



Rapid: Slow Peristalsis



Kneading Action



Pendulous Movement



Villi Mixing



Ileocecal Dilation

Edwin L. Dunaway, Conway, is the new chairman of the Arkansas Racing Commission. His appointment by Governor Faubus was announced August 9.

B. C. Page has joined O. W. Davenport in a general practice in Bauxite. He recently completed an internship at University Hospital in Little Rock.

H. R. Harris has finished an internship at Hillcrest Hospital in Tulsa, and has moved to Lewisville to open offices for a general practice.

Chris Christie is the pediatrician at the Medical Center in Crittenden Memorial Hospital in West Memphis. He joined Gilbert Jay III, and T. Murray Ferguson in July.

James M. Nisbett, a native of Jonesboro, is the new Chief Medical Officer for Veterans Administration Regional Office in Little Rock. His pre-med and first two years medical work were done in the University of Arkansas schools. He has maintained membership in the Arkansas Medical Society through many years of government service.

Paul Wright opened offices in Melbourne about August 1. He returns from two years' service duty, before which he operated a clinic in Lepanto.

Oscar Gray, Jr., has reopened his offices in Jacksonville for a general practice. He has been on active duty with the Navy.

Howard V. Monroe left Little Rock August 4 to occupy the offices of Dr. John A. Webb at Mountain View, who is taking special work in the University Hospital. It is a homecoming for Dr. Monroe who graduated from high school there as valedictorian of his class.

BOOK REVIEWS

A Textbook of Medicine: Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine Emeritus, Cornell University, and Robert F. Loeb, M. D., Bard Professor of Medicine, Columbia University, New York. Edition: Ninth. Pp. 1,786. 1955. W. B. Saunders Company, Philadelphia.

This superior Textbook of Medicine for beginner students is a must for the library of the seasoned practitioner of medicine, general practitioner, or internist. There are more than one hundred seventy contributors. The Editors have continued and improved its former, most inclusive, coverage and have added forty-four subjects not included in former editions. All of these are right-

fully included in as much as they are confronting the average practitioner much more frequently.

Colorado Tick Fever, Cosackie Viral Infections, Epidemic Hemorrhagic Fever, Cat Scratch Disease, Burning Feet Syndrome, and Pyridoxine Deficiency are among the newly covered subjects.

The format is pleasing and the entire book is most readable. Again, as in the past, the Editors have emphasized the physiologic and biochemical aspects of disease. This reviewer finds this to be the most complete single volume of Internal Medicine, available at this time. It is to be recommended most highly.—G. H. Butler, M.D.

New and Non-Official Remedies, 1955: Issued under the direction and supervision of the Council on Pharmacy & Chemistry of the American Medical Association. Pp. 653. Tables and Formulae. \$3.35. J. B. Lippincot Company, Philadelphia.

Sometimes the annual editions of a book are not given proper value because we casually observe that it's "just another edition." This observation is seldom correct. A new edition of New and Non-Official Remedies is not an old book "painted over." Hundreds of hours of work are spent in reviewing the various new remedies—new forms of the same remedy during the year of revision. Some 45 new drugs were added during the last year, 15 old ones were omitted, 8 were dropped because they were no longer manufactured. In each volume are the official rules governing admission of new drugs, and other notes, and explanatory comments. The text of the volume then devotes more than 400 pages on the content, and method of preparation of non-official remedies which are in use every day in every physician's office, and in every hospital. This valuable book is issued under the American Medical Association's Council on Pharmacy and Chemistry, and is a quick and complete reference for most drugs in use today. A thorough index makes it complete and easily used.

Differential Diagnosis: (The Interpretation of Clinical Evidence.) A. McGehee Harvey, M. D., Professor of Medicine and Head of the Department of Internal Medicine, The Johns Hopkins University, and James Bordley, III, M.D., Director, Mary Imogene Bassett Hospital, Cooperstown, N. Y.; Clinical Professor of Medicine, Columbia University, New York. Pp. 665. 1955. \$11.00. W. B. Saunders Company, Philadelphia.

This book has a fifteen-page Introduction which is perhaps the key section of the entire volume. It sets forth clearly the general methods to be used in diagnosis and differential diagnosis; the pitfalls which may be encountered and precautions to be observed in the diagnostic processes; and the logical manner of arriving at final diagnostic conclusions.

The main body of the volume is presented in a lecture or discussion form under both specific disease and symptom-physical sign headings. Very frequent use is made of presentations of complete clinical-pathological conferences of specific cases as illustrations of diagnostic procedures, reasoning, and conclusions.

This book is suitable for medical students only as an auxiliary reference text to be used in conjunction with, or supplementary to, more elementary texts of differential diagnosis.

It should be excellent for use by the practicing clinician, either specialist or general practitioner, as a ready, convenient, and helpful reference and review volume in diagnosis and differential diagnosis.—W. J. B.

The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

OCTOBER, 1955

No. 5

VAGINAL HYSTERECTOMY: INDICATIONS, CONTRAINDICATIONS AND TECHNIC*

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When a talk on a surgical subject such as vaginal hysterectomy is contemplated, it is necessary to make one basic decision: Should one stress the general aspects of the subject or should one go into the minutiae of surgical technic? I should like to place most of the emphasis today on when to do and when not to do vaginal hysterectomy and also to point out some of the pitfalls I have stumbled into and have had to get out of.

Vaginal hysterectomy has been done for a century and a quarter now, although the earlier reports were most often of freakish accidents with survival times to be measured in hours. However, in 1809, a planned vaginal hysterectomy was done and the patient survived 29 years before post-mortem examination revealed that the uterus had actually been removed, thus confirming the physician's statement. During the later years of the nineteenth century, vaginal hysterectomy was not an uncommon surgical procedure either by suture or by clamp technic. In the twentieth century, the abdominal approach was shown to be quite safe, so that it became the one of choice for most conditions of the uterus. Then, during the last 20 to 25 years, we have seen the indications for vaginal hysterectomy broadened until nowadays, in given circumstances, they include most of the indications for any hysterectomy.

General Considerations and Advantages

The uterus can be removed either vaginally or abdominally, and each method has certain basic advantages and disadvantages. If a patient is to have the optimal care with the least risk, then we must have surgeons capable and willing to remove the uterus either vaginally or abdominally, depending on objective criteria.

The postoperative mortality rate is a measure

of risk that is of some value. The mortality rate inherent in an operative procedure, especially a pelvic one, is minimal, being probably not more than 1 or 2 per 1,000 operations and perhaps less. This is modified by the anesthesia, the preoperative and postoperative care, the skill of the attending surgeon and the facilities available to the surgeon. Series of more than 1,000 cases of abdominal or vaginal hysterectomy with only one death has been reported. Even so, there is some risk to anesthesia and operation, and no patient should be advised to undergo an operation unless the surgeon and internist feel that the benefits will outweigh the risk.

If it is granted that the condition of the patient would be better if the uterus were removed, we immediately come to the choice of abdominal hysterectomy versus vaginal hysterectomy.

Since postoperative deaths are few and far between, they do not offer an adequate basis for comparison of the two basic methods of hysterectomy. Instead, postoperative morbidity as represented by significant increase of body temperature is used for this purpose, since it offers a fairly objective method of comparing the response of the patient to the operation in large series of cases. If the series is large enough, then age, minor differences in surgical technic, anesthesia, preoperative medication and the like should all average out. In a group of 323 cases of total abdominal hysterectomy reported in 1951, there were 88 patients, or 27.2 per cent, who had a morbid postoperative course when the criterion of morbidity was any increase of temperature to 100.4° F. on any 2 days following day of operation. In a second group consisting of 593 patients who underwent vaginal hysterectomy at the hands of the same surgeon as did patients in the first group and who were operated on during and after the time the patients in the first group were being

*Read at the meeting of the Arkansas Medical Society, Hot Springs, Arkansas, May 30 to June 1, 1955.

†The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.

operated on, there were 125, or 21.1 per cent, who had a morbid postoperative course.¹ This percentage is definitely lower than that for abdominal hysterectomy, and in 1 year the morbidity rate for the vaginal hysterectomy was only 12.7 per cent for 126 cases. For the combined groups the patients averaged 10 to 11 days in the hospital after the operation, but the patients who underwent vaginal hysterectomy without repair averaged only 7.5 days, counting the day of operation as the first day.

Vaginal hysterectomy is almost an extraperitoneal operation. The deep pelvis is opened, but only minimally, and there is little chance or danger of contamination of the peritoneum. Therefore, the risk of infection is slight and peritonitis is rarely seen as a postoperative complication.

Because the peritoneal cavity is not opened widely in vaginal hysterectomy, no exploration can be done; thus, on the basis that it permits better exploration, the abdominal procedure is more advantageous. But because no exploration is done during vaginal hysterectomy, there is no handling of the bowel and as a consequence there is no ileus and there is very infrequent complaint of gas pains. Abdominal discomfort is not a factor in the postoperative period. There is also no pain with motion of the abdominal wall on respiration, and therefore there is no splinting of the abdominal wall, there is less pressure on the diaphragm and pulmonary complications are fewer.

One of the greatest advantages of vaginal hysterectomy is the fact that obesity does not add appreciably to the technical difficulty of the operation. Obesity may give the anesthetist trouble when the patient is put in the lithotomy position, but vaginal removal of the uterus can be accomplished with moderate facility and with little trauma. Also, cardiac patients tolerate vaginal operations well, whereas an abdominal operation in such a patient does entail a distinct risk.

Since there is no abdominal incision in vaginal hysterectomy, there can be, of course, no postoperative infection of an abdominal wound and no ventral hernia. On the other hand, prolapse of the vaginal vault occasionally occurs, and this often results in a more difficult operation than was the vaginal hysterectomy.

Since the incisions, even with repair, are within the vagina and are somewhat protected, these patients can be allowed to return to normal activities somewhat earlier and much more comfortably than can patients with abdominal hysterectomy.

Finally, many patients have an associated cystocele or rectocele, or both, so that hysterectomy by the vaginal route carries right on into repair of the vaginal walls. On the other hand, if an abdominal approach is used for the hysterectomy, the repair almost doubles the time required for the operation and adds considerably to the loss of blood, so that the repair, therefore, may be put off to a second operation, with economic loss to the patient as well as continuation of whatever vaginal complaints the patient may have.

Contraindications

Attention is called to certain conditions that represent either real contraindications to vaginal hysterectomy or at least strong deterrents. A large adnexal mass is not a lesion that one wishes to approach from below. However, in a young woman a soft, movable, cystic tumor that should, on the basis of chance, be a benign cyst may sometimes be pulled into the vagina, drained with a trocar and possibly removed. At times there is real desire to explore the upper part of the abdomen for other lesions, and this may warrant the abdominal approach. A large uterus, that is, one that is 4 to 5 inches or more in its greatest dimension, can hardly be removed vaginally without morcellation or hemisection; hence, although both are satisfactory procedures, such a uterus is often better removed abdominally.

A history of pelvic inflammatory disease or a history suggestive of endometriosis should make a surgeon pause unless there is satisfactory freedom of the uterus and mobility of tissues on pelvic examination. Either of these conditions, especially pelvic inflammatory disease, can make the vaginal approach extremely difficult.

The problems that may arise because the patient has had previous pelvic operations should be considered. The fact that suspension of the uterus has been performed previously does not necessarily contraindicate vaginal hysterectomy unless the fundus is fixed anteriorly, but previous pelvic operations that have entailed shortening of ligaments and the formation of adhesions are a source of worry and may make mobilization of the uterus by the vaginal route most difficult.

Indications

Some of the advantages of vaginal hysterectomy over abdominal hysterectomy under similar circumstances have been presented. Now we can reasonably ask, What are the indications for vaginal hysterectomy?

Prolapse.—Prolapse of the uterus is, of course, the chief indication. Some surgeons in the past

have felt this to be the only real indication for vaginal hysterectomy, and without question prolapse is, in all series, the largest single reason given for vaginal hysterectomy. The prolapse may be such that the cervix hangs continually out of the vagina and must be replaced in order to allow the patient to defecate or urinate. Occasionally, the prolapse is complete, with the uterus, bladder, rectal wall and vagina all being outside the body when the patient is on her feet; technically, repair of such a prolapse presents one of the most confusing problems that the pelvic surgeon will encounter.

Usually, descensus is of grade 1, 2 or 3 (on a basis of 1 to 4) in which there are moderate relaxation and descensus but in which the cervix is still at least within the vaginal introitus under ordinary circumstances. In such cases, hysterectomy is not a pressing need. However, if the patient also has poor support of the vaginal wall, with cystocele and rectocele, and if she is having discomfort, a sensation of bearing down or a feeling of lack of support, or if she is also incontinent, then vaginal hysterectomy and repair of the vaginal wall at the same time constitute the procedure of choice. Repairs of the vaginal walls is necessary in a majority of cases. Counseller and Hunt,² in 1952, found that repair of the interior or posterior wall was necessary in 309 of 401 vaginal hysterectomies (77.1 per cent). Gray³ repaired either the anterior or the posterior vaginal walls or both, in 93 per cent of 190 cases.

Not infrequently, especially in menopausal or postmenopausal patients, all the symptoms seem related to the cystocele or rectocele. In these patients the uterus is generally small and atrophic. If such a patient is to undergo anesthesia and repair of relaxed vaginal walls, it adds relatively little to the procedure to remove the uterus at the same time. One then has the added advantage of being able to visualize the adnexa and to remove them if they are diseased. If an enterocele is present, it will be identified, the sac can be excised, and repair of the posterior wall can be started at a higher level.

Abnormal Bleeding.—Abnormal bleeding not due to malignant disease is the second most valid reason for vaginal hysterectomy. Menorrhagia with anemia can occur at any age; if it is excessive and if anemia is marked in spite of iron therapy, and if the menorrhagia is not controlled by conservative methods, one must consider further steps. In women less than 35 years of age, curettage should be done first with the hope that the abnormal bleeding will be favorably changed even if no small submucous fibroid or polyp is

found and identified. If curettage is not effective, vaginal hysterectomy should be considered. Menorrhagia or metrorrhagia due to ovarian dysfunction and menometrorrhagia associated with a large boggy, subinvolved uterus are also indications for removal of the uterus if medical measures are not effective. In any case, dilatation and curettage are advisable if there is metrorrhagia. Patients with metrorrhagia whose ages generally are in the high thirties or low forties, are those who 15 to 20 years ago were frequently treated with a menopausal dose of radon. About 10 per cent of the patients so treated came to hysterectomy anyway and all had practically complete loss of ovarian activity. Vaginal hysterectomy controls the bleeding in 100 per cent of the patients, it does not affect the age at which the ovaries become inactive and it removes the danger of subsequent carcinoma of the endometrium which occurs in a few patients in all groups treated with menopausal radon, as disclosed by observation of such patients over a period of years.

Carcinoma in Situ.—Carcinoma in situ has become of increased importance to the pelvic surgeon. This lesion, which represents stage 0 of carcinoma of the cervix, can be suspected, on the evidence of abnormal cells in a vaginal smear, long before it can be seen or felt. Cervical biopsy may confirm the presence of a tumor but **not** the extent of the lesion. My colleagues and I⁴ have found that removal of the uterus is likely to prove curative in practically 100 per cent of cases; at least, we have not observed any implants or metastatic lesions in our series of cases as yet. Amputation or cauterization of the cervix may leave some of the malignant tissue still in the endocervix or even on the edge of adjacent parts of the vagina, and such treatment should be used only with the full knowledge and wishes of the patient after she has been advised that another procedure offers a greater chance of cure. The uterus can be removed either vaginally or abdominally; although associated repairs for relaxed vaginal walls should theoretically predispose to implantation of malignant cells, we have not yet encountered such implantation. In 1952, at the Mayo Clinic, 42 of the 401 vaginal hysterectomies were done for carcinoma in situ, and the total number of in situ carcinomas of the cervix being diagnosed is increasing each year.

Postmenopausal Bleeding.—Postmenopausal bleeding is a serious sign—it is very often the first symptom of endometrial carcinoma; therefore, it must always be investigated thoroughly. Even though senile vaginitis of some degree is present, diagnostic dilatation and curettage probably rep-

resent the most conservative procedure to be advised, watchful waiting being the most risky and even foolhardy. The surgeon and the patient should discuss the possible causes of the bleeding and the methods of treatment. If there is an associated prolapse, if the bleeding has been recurrent, or if previous dilatation and curettage have been done, I believe that vaginal hysterectomy should be seriously advised.

Fibroids.—Fibroids that are causing bleeding, or symptomless fibroids that are changing in size or that are 2 or 3 inches in diameter when the patient is first examined, may often be removed vaginally if there is moderate relaxation of the introitus and perineum. Morcellation or hemisection of the uterus after ligation of the uterine arteries may be necessary, but this adds little if anything to the risk even though it prolongs the operation for a few minutes.

Carcinoma of the Uterine Fundus.—It is generally considered that carcinoma of the uterine fundus is best treated by abdominal hysterectomy. A recent follow-up of patients who had undergone vaginal hysterectomy for such a carcinoma revealed that 67 of 81 traced patients (82.7 per cent) survived 5 years.⁴ The tumors in these cases were generally low-grade lesions of small extent. The decision for vaginal hysterectomy was made on this basis alone or on the basis that an abdominal operation would add materially to the risk. Obese, elderly patients and patients with poor cardiac reserve or with hypertensive or arteriosclerotic disease were the ones selected for vaginal hysterectomy or irradiation rather than for abdominal hysterectomy.

Cervical Erosion.—Cervical erosion in the woman more than 40 years of age poses a problem. There should be no risk connected with cauterization in the office. There is a little risk connected with vaginal hysterectomy. A patient whose cervix has been cauterized must be kept under observation for a few days. The cervix will take 4 to 10 weeks to heal and the erosion may recur. When vaginal hysterectomy is performed, the patient may well be dismissed before 2 weeks have passed. The discharge generally ceases in 2 to 4 weeks and there can be no recurrent cervical erosion.

Dysmenorrhea.—Dysmenorrhea is a not uncommon indication for vaginal hysterectomy. If this procedure is contemplated, it is to be assumed that conservative measures have been tried extensively and that the patient is no longer concerned with her reproductive function. In such a situation, vaginal hysterectomy offers an ideal

solution with minimal risk, no hormonal changes and with an excellent possibility of relief of symptoms; seven of the 401 vaginal hysterectomies in 1952 were done for this reason.

Miscellaneous Indications.—Miscellaneous indications for vaginal hysterectomy depend on the ease with which the individual surgeon can perform the operation. Visualization of a mass in the cul-de-sac that otherwise would entail abdominal exploration, stage II carcinoma of the cervix in complete procidentia, and dyspareunia are some of the more uncommon preoperative reasons given for doing a vaginal hysterectomy.

Technic

Though vaginal hysterectomy can be, and in the past often was, performed with the patient in the Sims position, it is far more easily performed with the patient in the lithotomy position. The vagina is first scrubbed with soap and water and then is painted with a solution of merthiolate (ethylmercurithiosalicylate) or phemerol (benzethonium). The bladder is **not** catheterized. The presence of urine in the bladder does not impede the progress of the operation; if an opening is inadvertently made into the bladder, the gush of urine over the surgeon's hands is characteristic and confirmatory of the difficulty encountered. A weighted speculum will satisfactorily hold down the perineum and expose the vaginal tract, while two or three Deever retractors will adequately expose the cervix.

A circular incision is made about the cervix and the vaginal mucosa is pushed away from the cervix to expose the submucosal fascias. When little prolapse is present, the incision is kept close to the cervix; if the prolapse is marked, then the lateral portions of the incision are carried out toward the corners of the vagina. In any case, it must be kept in mind that the bladder is usually adherent well down on the uterus toward the cervix; therefore, the anterior portion of the incision must be very near the cervix to avoid injury to the bladder.

The cervicopubic fascia is divided near the cervix, and the bladder is then pushed up and off the anterior uterine wall; this exposes the peritoneal fold of the anterior cul-de-sac. In this step the lateral attachments of the bladder are pushed back and laterally along the uterine vessels and broad ligaments. The anterior cul-de-sac is then opened and, with a Deever retractor in the anterior cul-de-sac, the base of the bladder and with it the lower ends of the ureters are kept elevated. The posterior cul-de-sac is generally entered without difficulty unless the patient has endometriosis. When this condition is present, the surgeon

must dissect very close to the posterior wall of the uterus until the free peritoneal space is entered.

The uterosacral ligament is identified by a finger through the posterior cul-de-sac. Then, with Heaney clamps, a large bite is taken on one uterosacral ligament as far laterally as is feasible and the ligament is divided and stick-tied. The cardinal ligament and the uterine artery are next divided and ligated; since the bite for this purpose may be very close to the ureter, it is well to examine the tissues with a finger and to identify the position of the ureter, if possible, before these structures are crushed. Similar ligaments on the opposite side of the uterus are then clamped and stick-tied, so that the lower two-thirds of the uterine supports are freed.

The fundus of the uterus can generally be brought out through the posterior cul-de-sac, and clamps are finally placed on both utero-ovarian ligaments including the anastomotic vessels, the round ligaments and the tubes. These ligaments are divided and stick-tied, and the uterus is removed. The surgeon is then in an excellent position both to see and to examine the adnexa; if tubal or ovarian disease is present, the offending organ or the entire adnexa can be removed.

After examination of the adnexa the peritoneum is closed with a continuous suture, all raw surfaces being extraperitonealized. The vault is closed by first carrying a suture through the vaginal mucosa at the lateral corner of the incision and then transfixing the uterosacral ligament of that side and bringing the suture back through the vaginal mucosa where it is tied. A second stitch fixes the cardinal ligament and the utero-ovarian ligament into the corners of the vault also. Then the vaginal mucosa is closed transversely from the corner medially to approximately the middle of the finished closure. A similar attachment of the ligament of the opposite side is made and the remaining half of the vault closed. When there is little or no cystocele or rectocele and no repair is needed, there will be practically no shortening of the vagina by such an operation.

If a cystocele that needs repair is present, the anterior vaginal wall is split in the midline from the closed vault to within 1 cm. of the urethral meatus and the cervicopubic fascial layer is separated from the vaginal mucosa as far laterally as the descending rami of the pubic bones. The bladder is then retracted upward and the fascia is closed from below forward with one or more rows of catgut sutures depending on the degree of the cystocele. A few interrupted sutures may be placed advantageously at the neck of the bladder if desired for additional support. The

excess vaginal mucosa must be excised, and the mucosa can be closed in the midline with interrupted sutures.

The rectocele and the perineum are repaired last, since the added exposure with the weighted speculum before repair of the postvaginal wall facilitates the progress of the operation. Tena-culum forceps are placed on the lower portion of each labium where their approximation will leave a normal introitus. The forceps are landmarks forming the base of a triangle whose apex is as far up the posterior wall of the vagina as it is necessary to go to repair the rectocele; frequently, this triangle will extend to the transverse closure of the vaginal vault. The triangle of vaginal mucosa thus outlined is now excised and the posterior wall is closed with a continuous suture starting at the apex, the suture deliberately catching rectovaginal fascia as well as vaginal mucosa. As the outer portion of the vagina is approached, the levator ani muscles are identified and are approximated in the midline with interrupted sutures, and similar sutures are utilized to bring the transverse perineal tissues together.

The operation is finished by the insertion of a few interrupted sutures in the skin of the perineum. The vagina is packed with iodoform gauze and, if a cystocele has been repaired, a catheter is placed in the bladder. Then the bladder is immediately emptied, so that all subsequent urine from the catheter represents urine secreted and drained after the operation has been completed.

Summary

Vaginal hysterectomy, when compared with abdominal hysterectomy, has the advantage of an equal or better mortality rate and a definitely lower postoperative morbidity rate. Also, obesity does not add materially to the technical difficulties of vaginal hysterectomy, and the operation is well tolerated by obese patients as well as by the elderly and by cardiac patients. The extraperitoneal nature of vaginal hysterectomy is associated with a low incidence of infection and ileus. The inability to explore the abdomen is offset by the loss of abdominal pain, the lack of splinting of the abdominal wall and undue pressure on the diaphragm, and the occurrence of fewer pulmonary complications. The incisions are well protected, and early return to normal activities is permitted.

Vaginal hysterectomy is contraindicated for large adnexal masses, for conditions in which exploration of the abdomen is required, and for large uteri with no descensus. Pelvic inflammatory disease and endometriosis are serious deterrents to the procedure, and the possible difficul-

ties created by previous pelvic operations should always be evaluated.

The indications for vaginal hysterectomy, presented in order of descending importance, are: prolapse, abnormal bleeding, postmenopausal bleeding, carcinoma in situ of the cervix, fibroids, carcinoma of the uterine fundus, cervicitis, dysmenorrhea and a group of miscellaneous conditions.

The technic of vaginal hysterectomy is summarized.

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"IRON METABOLISM AND THE PATHOGENESIS OF HEMOCHROMATOSIS"*

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Great strides have been made in recent years in our knowledge of iron metabolism and the pathogenesis of hemochromatosis. A review of this interesting subject, I believe, is timely in order to crystallize some of the new information and critically review some of the old.

Hemochromatosis was first described by Hartman and Chausser in 1882 as "bronze diabetes" because of the association of skin pigmentation with diabetes mellitus. Von Recklinghausen, in 1889, found deposits of hemosiderin and hemofuscin in the viscera. At this time, hemochromatosis was thought to be quite rare, being clinically diagnosed only three times in 160,000 admissions to John Hopkins Hospital, and on post mortem examinations, only four times in 5,000 autopsies at the Bellevue Hospital. By 1935, Sheldon was able to collect 311 acceptable cases, and at the last complete review of the literature in 1941, there were 436 cases, indicating probably a keener awareness of the disease.

Classically, hemochromatosis occurs in the male, the ratio being 295 males to 16 females in Sheldon's series. It is practically unknown before the age of twenty, and has its peak incidence between forty-five and fifty-five years.

The fully developed disease presents: (1) an enlarged liver caused by marked deposition of hemosiderin and a hypertrophic cirrhosis; (2) a bronze pigmentation of the skin, most common on the face, neck, arms, legs and genitalia; the pigmentation is not caused by hemosiderin deposition, but by increased melanin deposition in the basal

layers of the skin; (3) diabetes mellitus of a moderately severe type (average insulin requirement is 62 units) due to fibrosis and deposition of hemosiderin in the pancreas; (4) a form of sexual hypoplasia characterized by testicular softening and atrophy, with a decrease in the amount of body hair. The impotence is a relatively late manifestation of the disease and is thought to be caused by the inability of the diseased liver to detoxify estrogens, and thereby an increased concentration of estrogens in the blood. However, Althausen found that the sparsity of body and facial hair had been present in his cases during their entire adult life, and was thought to be a constitutional characteristic. The disease, in time, is inevitably fatal, death resulting from diabetes or complications of diabetes, cirrhosis of the liver, or carcinoma of the liver.

The two types of pigment found in hemochromatosis are hemosiderin and hemofuscin. Hemosiderin is a golden yellow pigment which contains about 55% iron. It is the predominant pigment in hemochromatosis and is most abundantly found in the liver and pancreas. However, no secreting gland in the body is spared. Considerable quantities of the pigment are found in the reticulo-endothelial system. Hemosiderin is usually not found in the epidermis, but occurs in the cells of the sweat glands. Hemofuscin is a dark, almost black pigment, which does not contain iron but does contain about 3.7% sulphur. It is probably related to melanin. It occurs most often in the smooth muscles of the genital and alimentary tracts, and the smooth muscles of the arteries. It

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also occurs to a lesser extent in the glandular organs of the body.

In order to understand our present knowledge of the pathogenesis of hemochromatosis, we must first review the metabolism of iron. The average dietary contains 5-10 mg. of iron. Approximately 10% of this amount is normally absorbed by the duodenum and jejunum, and the remainder is excreted in the feces. So the normal male absorbs approximately 0.5-0.9 mg. of iron daily, and loses approximately this much through epithelial desquamation and small losses in the urine, feces and perspiration. The intake and excretion of iron for the female is higher because of the loss of iron in the menses and parturition.

Normally, it appears that the absorptive process somehow operates to prevent the passage of undesirable amounts of iron into the body. It has been definitely proved that the normal male, even in instances of iron over-load, is unable to excrete more than minimal (0.5-1.0 mg. daily) amounts of the metal.

In the normal 70 kg. man there are about 4.2 grams of iron. About 93% of this can be accounted for in some six different organic compounds, and there is little room left for inorganic iron. Approximately 76% of the body iron is in the hemin chromoproteins, hemoglobin alone accounting for 73%. About 16.5% is present in two iron protein complexes, ferritin and siderophilin. Apoferritin (iron free) is a protein of large molecular weight (about 465,000). When converted into ferritin by saturation with iron, it contains 23% by weight of the metal.

Ferritin is a protein-colloidal ferric hydroxide-phosphate complex. It has been found in the spleen, liver, kidneys and red bone marrow. It is present in greatest concentration in the liver and duodenal mucosa.

The iron in the plasma exists normally only in combination with a beta-1 pseudoglobulin, called siderophilin. Siderophilin has been crystallized, having a molecular weight of about 90,000, and forms about 3.3% of the total plasma proteins.

The normal plasma iron is approximately 100 gamma%. The siderophilin is only 32% saturated in the normal man. Since there are about three liters of plasma in the average 70 kg. man, there would normally be only 3 mg. of the iron carried in the plasma. The iron binding capacity of siderophilin is three times the normal or approximately 315 gamma%. The capacity, at saturation, of the siderophilin iron is but three times the normal level, or 9 mg.%. This means that there

is a limited capacity of physiological iron transport and this fact should be kept in mind when giving iron parenterally.

Our present concepts of iron metabolism are the following: Iron is taken in food in the ferric state. It is reduced in an acid medium by ascorbic acid to the ferrous form. The ferrous iron is then absorbed by the duodenal and jejunal mucosal cells and converted to the ferric form. In the mucosal cells, it becomes attached to apoferritin, forming ferritin. It is converted again into the ferrous state and released into the blood stream. Here, at once, it combines with siderophilin (transport mechanism) and is carried to the liver, spleen and bone marrow. In these sites, the ferrous iron is oxidized to the ferric form and again unites with apoferritin and is stored in these organs, principally the liver, as ferritin. Ferritin does not stain, but when large amounts of iron are present, it is stored as hemosiderin granules. Hemosiderin granules do take the iron stains readily and are easily recognized with the microscope.

Recent reasonably accurate radio-active iron balance studies have shown conclusively that the defect in hemochromatosis is increased iron absorption from the gastro-intestinal tract. The mechanism of this increased absorption is not known.

When 5-15 gamma of radio-active iron (ferric chloride) was given orally to normal males, 1.5-4.4% of the ingested dose was absorbed, whereas patients with hemochromatosis absorbed 20-45% of this dose. This increased absorption, if continued over a long period of 20-30 years, coupled with the negligible excretion, will result in the accumulation of enormous quantities of iron in the body. Such a mechanism has been proved in hemochromatosis.

In hemochromatosis, the serum iron is elevated to an average of 213 gamma%, and the total iron binding capacity averages 246 gamma%, representing a 94% saturation. A peculiar phenomenon in hemochromatosis is that even though the fasting iron binding capacity is increased, it cannot be completely saturated by giving large doses of iron.

During the past ten years, increasing numbers of cases of marked hemosiderosis with pigmentation of the skin, diabetes and hepatic and pancreatic fibrosis have been reported in cases of malnutrition and chronic refractory anemias, with or without blood transfusions. Some authors are now dividing the cases into primary or idiopathic hemochromatosis, and secondary hemochromato-

sis. The following diseases or conditions are associated with the increased absorption of iron from the gastrointestinal tract; (1) Fever, (2) cirrhosis of the liver, (3) all anemias, regardless of etiology, (4) malnutrition, (5) low phosphorus diet, and (6) experimental conditions. Of the above conditions which might lead to a chronic and prolonged increase of iron absorption are (1) experimental conditions, (2) malnutrition, with or without cirrhosis of the liver, and (3) chronic refractory anemias.

Experimental Hemochromatosis

Mallory, in 1921, gave rabbits copper acetate for as long as twelve months. He produced pigmentation similar to hemofuscin and cirrhosis in three rabbits. Taylor, Stiven and Reid in 1931, induced hemochromatosis by depancreatizing a cat and giving it a poorly balanced diet. Polson gave iron subcutaneously and intraperitoneally for periods ranging from one to four years. Hemosiderin was deposited in the tissues in large amounts, but cirrhosis did not develop. In 1946 Herbut, Watson, and Perkins found all the manifestations of hemochromatosis in two of their thirty rabbits with alloxan diabetes. Undoubtedly, the time interval is too short for iron over-load per se to produce cirrhosis and diabetes. Indeed, it is not definitely known if hemosiderosis per se will produce cirrhosis of the liver and pancreas.

Hemochromatosis and Malnutrition

The most important contribution in this field was that of Gillman and Gillman in 1947. They demonstrated by liver biopsies that hemochromatosis was a common disease in South African pella-grins. They proposed the term cytosiderosis be used instead of hemochromatosis, since the latter term implies that the pigment comes from the blood (which is incorrect) and that cirrhosis of the liver invariably be present.

Kremer has shown an increase in iron pigment in the liver of hibernating and starving frogs. Taylor, Stiven, and Reid produced cytosiderosis in the cat by an unbalanced diet (corn grits). Sheldon states that hemosiderin deposition in ordinary cases of portal cirrhosis is a constant finding, but not of the magnitude as in hemochromatosis. The incidence of alcoholism is definitely increased in hemochromatosis. Sheldon reported that 70% of a series of 83 cases gave a history of alcoholism. Althausen reports that 10 of 20 cases had a history of excessive alcoholic intake. However, there was no history of a dietary deficiency in these individuals.

Hemochromatosis Associated With Chronic Anemias and Blood Transfusions

During the past ten years, many instances of hemosiderosis with and without cirrhosis of the liver have been reported in patients with chronic refractory anemias. All types of chronic refractory anemias have been incriminated, except the iron deficiency anemias. This would include the following types: (1) chronic hemolytic anemias of all types, (2) anemia of chronic infections, (3) hypoplastic anemias, (4) pernicious anemia in relapse, (5) anemia with malignancy, (6) myelophthisic anemias and (7) anemia of malnutrition, and others.

Transfusions have been given an undue amount of stress in the etiology of this disease. The iron content of the body in these cases has been reported as high as 47 grams. The number of transfusions range from 4 to 200. The average iron content of 500 ml. of blood is 250 mg. In most cases, the iron from transfusions is only a small contribution to the total amount in the tissues.

All of the stimuli for increased absorption of iron from the gastro-intestinal tract are not known, but two facts are apparent. (1) Any type of anemia will cause increased absorption and (2) The level of serum or tissue iron has no effect on absorption under abnormal conditions. It is frequently stated that there is no anemia in hemochromatosis. They quote that in Sheldon's collection of 311 cases, the average hemoglobin was 80% and the average red blood cell count was 4.1 million. However, on closer reading of Sheldon's monograph, the following facts will be found (1) the red blood cell count and hemoglobin were reported in only 94 cases; (2) The red cell count was below 4 million in 37% of the cases and in 10% of the cases there were red counts of less than 2.5 million.

Comment

The relationship of "secondary hemochromatosis" caused by chronic refractory anemias and transfusions, cytosiderosis of Gillman, and primary hemochromatosis is problematic. Pathologically, the end result of all three is the same, hemosiderosis and cirrhosis of the liver. The serum iron levels and the iron binding capacity are the same in primary hemochromatosis and secondary hemochromatosis caused by refractory anemias. These chemical determinations were not reported in Gillman's cases.

By definition, two conditions must be present for the diagnosis of hemochromatosis; (1) hemosiderosis and cirrhosis of the liver (2) these two criteria are met in many of the cases of secondary

hemochromatosis. Considerable latitude is being given to these criteria for diagnosis, and today many cases of chronic anemias with hemosiderosis and moderate amount of fibrosis are being called secondary hemochromatosis.

The term, hemochromatosis, is actually a misnomer in that the increased pigment does not come from the blood as was thought when the disease was first described. However, time honored usage will prevent its replacement.

The predominant male incidence of this disease (20 males to 1 female) has long been of interest to investigators. It is now generally believed that the blood loss of the female through the menses and parturition, protects the female from iron overload. In many of the females with hemochromatosis the menstrual flow has been scant and the menopause has been early. The mean periodic iron loss in the female has been calculated as 17 mg. During gestation the drain of iron from maternal stores is about 350 mg. or some 60% greater than the amount lost yearly in the menses. It is also of interest that in the 16 female cases reported by Sheldon, 5 or 31% were chronic alcoholics.

Hemochromatosis has been reported in two members of the same family. It developed in identical twins at about the same time. Sheldon reports 5 instances of familial disease in his collection of 311 cases. In these cases the only defect presumably was increased absorption of iron. These cases are thought to represent an inborn error in metabolism of iron, congenital in origin.

Conclusions

I. Hemochromatosis is a disease complex, which may be caused by: (1) inborn error of iron metabolism, (2) chronic refractory anemias, (3) large numbers of whole blood transfusions, and (4) chronic malnutrition.

I. Hemochromatosis is a disease complex,

II. In the human, particularly the male, there is normally less than 1 mg. of iron absorbed daily, and there is no mechanism to provide for the excretion of significant amounts of this metal.

III. The defect in hemochromatosis is increased absorption of iron from the gastro-intestinal tract.

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CREATION OF A COMMITTEE FOR THE DISTRIBUTION OF SALK POLIO VACCINE WITHIN THE STATE OF ARKANSAS

A state committee shall be set up to control the intrastate distribution of Salk Polio Vaccine in an effort to keep the distribution on a voluntary basis. The committee shall be composed of (1) the State Health Officer as chairman, (2) the chairman of the polio advisory committee of the State Medical Society, (3) a representative from the Arkansas Academy of General Practice, (4) a representative of the Arkansas Pharmaceutical Association, and (5) a representative of the State Department of Education. The representatives of the Academy of General Practice and the Arkansas Pharmaceutical Association will be named by the presidents of their respective organizations. The representative of the State Department of Education will be named by the Commissioner of Education. This committee shall meet at the call of the chairman thereof for the purpose of devising a plan for the equal and fair distribution of Salk polio vaccine among the physicians of the State. The committee will give widespread publicity to their plans through the press and all other expedient means of communication.

This committee recommends the following plan for distribution of Salk polio vaccine to the private physicians of the State.

Plan for Distribution of Salk Vaccine to Private Physicians in Arkansas

PURPOSE

The purpose of this plan is to furnish information to all interested physicians, druggists, hospitals, and allied medical organizations regarding the present status of Salk poliomyelitis vaccine. It will further arrange for the equitable distribution of available supplies of Salk polio vaccine, provide for recording of the amounts received in Arkansas at each level of distribution; and outline the essential data to be recorded and kept by the physician who administers the vaccine. This plan, when put into operation, will remain in effect so long as the supplies of vaccine are insufficient to meet the demands or until superseded or modified either at the interstate or intrastate level.

ASSUMPTIONS

1. That limited amounts of Salk polio vaccine are available at this time and only limited amounts will be available for some months to come.

2. That those age groups most susceptible to polio infections will be given priority in receiving polio vaccine. The National Advisory Committee on Poliomyelitis Vaccine recommends that the 5-9 age group be given first priority when the N.F.I.P. school program for giving polio vaccine has been completed. In Arkansas the next group will be the 0-4 age group, next the 10-14 year group, and then the 15-19 year group.

3. That the distribution of vaccine to the various counties in the State of Arkansas will be based on what the per cent of children in the priority age group in a given county bears to the total number of persons in that age group in Arkansas. The total amount of vaccine available at a given time will be multiplied by these factors to determine the amount of vaccine which can be allotted to any given county.

Example: 100,000 cc vaccine available October 15, 1955. County X has 1,124 children in the 5-9 year group. The total 5-9 population is 202,063. 1,124 divided by 202,063 equals .0055. The factor .0055 would apply, which times 100,000 equals 550 cc vaccine available to County X.

4. That there will be agreements between the Federal government and the manufacturers for allotting Salk polio vaccine to the State.

5. That the total allotment to the states will consist of two portions: (1) that for commercial use and (2) that which will be supplied as grant-in-aid to the State. The State Health Officer is administratively responsible for all Salk poliomyelitis vaccine shipped into the State.

OPERATING PROCEDURE—RECORDS AND RETURNS

1. All manufacturers of the vaccine will, at the time of shipment of any lot of vaccine, notify the State Health Officer, furnishing copy of each bill of lading showing to whom shipped, date, and amount.

2. Retail pharmacies (including surgical supply houses) will prepare each Friday a weekly report, in duplicate, of vaccine sold, mailing the original to the State Health Officer, Box 1941, Little Rock, Arkansas. This report, to be made on a standard form, will give the name of the pharmacy with its address, showing date of report, with the number of cc's of vaccine on hand at end of week covered by the report. This report will also give a record of the amounts of vaccine received during the week. There shall be listed the dates of sales, to whom, with address, town and state, manufacturer of vaccine, lot number and number of cc's sold.

3. Each purchaser of vaccine (physician or other medical practitioner) will keep an individual record of each cc of Salk polio vaccine administered, recording the patient's name, complete address, age, sex, color, amount of vaccine administered, site of inoculation, manufacturer of vaccine, with lot number and date administered. This record **must** be kept and be available to the State Health Officer or his authorized representative at all times.

4. Vaccine that may be furnished through the State Health Department or other public agency will receive prior approval by the State Health Officer. Records of shipment to health departments and/or physicians for administration will be maintained at the supply office in the State Health Department. Individual records will be made upon persons to whom the vaccine is administered just the same as that kept by the physician.

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Quiz
for
doctors

A

you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle



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TRUE NOW AS THEN

It is amusing to read and hear of the passing of the family physician. There never was a time in our history in which he was so much in evidence, in which he was so prosperous, in which his prospects were so good or his power in the community so potent. The public has even begun to get sentimental over him! He still does the work; the consultants and the specialists do the talking and the writing; and take the fees! By the work, I mean that great mass of routine practice which brings the doctor into every household in the land and makes him, not alone the adviser, but the valued friend. He is the standard by which we are measured. What he is, we are; and the estimate of the profession in the eyes of the public is their estimate of him. A well-trained, sensible doctor is one of the most valuable assets of a community, worth today, as in Homer's time, many another man. To make him efficient is our highest ambition as teachers, to save him from evil should be our constant care as a guild.—Sir William Osler, 1902.

BUY
U. S. SAVINGS
BONDS

— ★ Editorial ★ —

LEADERSHIP

Sometimes we get just as concerned about things that are happening within our own house of Medicine as we do about the restrictions that the Socialists hidden in our Government are putting on us to rob us of the independent practice of medicine.

In 1953 the House of Delegates of the American Medical Association ordered formed a "Committee on Medical Practices," referred to as the Truman Committee, because its chairman was Dr. Stanley Truman, San Francisco.

This Committee reported in full at the December meeting of the Association in Miami in 1954, with recommendations for action. For some reason the Board of Trustees who received the report saw fit to see that the report was not given to the Delegates and it was only after considerable effort, and many months, that the report was let out. Even the Chairman of the Committee refused to release the report, to the Delegates, stating that the Board of Trustees considered it Confidential! A request from a State Journal to Secretary Lull's headquarters got the answer that only one copy was available and that it could not be reproduced before the AMA meeting in June. That statement was just a little astounding.

Actually the report was not made available to the Delegates of the AMA until after one delegate forced the issue and demanded that the Delegates be allowed to see the full report on which they were about to vote. A copy has at last been made available to the **Journal**, though it did not come through official channels.

The AMA has nothing to hide. Arkansas trusts her Delegates and resents the fact that they were not allowed to see and study the report.

If the Board of Trustees is to lead us, let them lead us in the light.

THE DOCTOR AS A HOSPITAL PATIENT*

THOMAS G. JOHNSTON, Little Rock

The purpose of this communication is to attempt to improve the hospital public relations, from the standpoint of the physician. My qualifications to write on this subject arise from having spent two and one-half weeks, in the spring

of 1955, as a bed patient. It was during this period of hospitalization that for the first time I understood the functions and services of the hospital.

One frequently hears the statement made that the cost of hospitalization is prohibitive. Actually the cost of hospitalization has not risen as much as food and other prices. Formerly one could get twenty-five cent haircuts; now they are \$1.25. Only four cents out of every dollar is being spent toward one's health which includes pay to physicians, hospitals, and medications. Recently my sister was hospitalized and when asked by my brother-in-law why it cost fourteen dollars a day for a room in the hospital I was unable to give him an adequate answer. However, I now feel that I have excellent answers for the necessity of such a fee. At least twelve people or more are directly concerned with services rendered to the hospital patient. This, of course, includes food, laundry, nursing, medications, air conditioning, plumbing, and other essential function of a hospital. Salaries now take up more than half of the expenses of a modern day hospital.

The following are some suggestions as to what the Medical Staff can do to improve our hospital public relations:

We must tell our patients about the services which are rendered. We should stress to them that actually hospitalization is a good buy. We should emphasize the expense involved in giving people three meals a day in bed. Try going to a first class hotel and having three meals served to you in bed daily. You'll be unpleasantly surprised at the expense involved.

Also tell the patient about the shorter stay which is necessary now than before. With the advent of modern techniques and new medications, the period of hospitalization per person has been reduced two-thirds.

One of the most important points we can make is to explain to our patients that health is not a luxury but is a necessity. Many people spend more money and take better care of their cars than they do their bodies. It is not unusual to see a man with a million dollar business, who takes very poor care, if any, of his own health.

Also we should tell our patients that people are living much longer and much more productive lives. Here again the hospital plays an important role in making this possible.

*Received for publication, 18 August 55. Journal, Arkansas Medical Society.

We should explain to our patients that one cannot put a price tag on relief of pain. Demerol^(R), which I received for relief of severe sub-sternal pain radiating into my left arm, was invaluable. Certainly, I would gladly have given up what little earthly possessions I had just for relief of that unbearable pain. We let our patients take these things for granted whereas we should be pointing out that any time, day or night, there are nurses and doctors on duty to help relieve one's pain and suffering.

We must tell our patients that the few minutes daily that we spend with them is only a small amount of the time which we spend studying their charts and X-rays and writing orders. Some of the complaints frequently heard are that the doctor spends too little time with the patients. If we'll explain to the patients that by far the majority of our time is spent writing orders, studying their charts, studying X-rays, etc., they will understand the doctor's fees for their hospital care.

We should tell our patients that good health is one's most important asset. For without health one cannot enjoy his home, his family, his friends, his work, or his hobbies. Obviously, the hospital plays a very important role in keeping us in good health.

And lastly, the hospital's readiness to serve 24 hours a day cannot be measured in dollars and cents.

COUNTY MEDICAL SOCIETIES STAND UP AND BE COUNTED

The response to the request of the Directors of State Sanatorium has been excellent. Jackson, Hempstead, Pulaski, and other counties have already responded to the plea voiced through the State Health Officer that the societies urge their members to do the follow-up treatments of patients released from the State Sanatorium.

Arkansas physicians announced they would donate their own services in giving treatment "shots" to indigent patients who might otherwise be forced to remain at the sanatorium.

Jerome S. Levy, Little Rock, President of the Arkansas Tuberculosis Association, pointed out that this is not a departure from policy, but a reaffirming of the physicians of their willingness to treat diseased indigents with the same care that is given to other patients.

Calling attention to this charitable service will allow some of the patients who are in the Sanatorium to return home, and be treated by their family physician.

REPORT YOUR CASES

We are urged by authors, Anderson and Hermann, in the June 25th Journal of the American Medical Association to report any case or cases of twins who have leukemia. Research centers need data on such cases, and every physician is urged to send such in. Reference is made above to the original report.

OUR MONA GETS AROUND

Mrs. Mason Lawson, Little Rock, President of the Woman's Auxiliary to the American Medical Association, attended the following State Medical Association meetings in her official capacity:

Utah State Medical Association, Salt Lake City, September 8-10;

Washington State Medical Association, Seattle, September 10-14;

Montana Medical Association, Bozeman, September 15-18;

Michigan State Medical Society, Grand Rapids, September 27-29;

Vermont-New Hampshire Medical Societies, Breton Woods, New Hampshire, September 30-October 2.

She conducted State Woman's Auxiliary Conferences in California on September 19-23; in Minnesota October 4, and Illinois October 6-7.

As President of the Auxiliary, Mrs. Lawson also attended the AMA Public Relations Conference in Chicago August 31-September 1 and the AMA Conference on Physicians and Schools held October 12-13 at Highland Park, Illinois.

COMING ATTRACTIONS:

OKLAHOMA DIVISION: AMERICAN CANCER SOCIETY

Huckins Hotel, Oklahoma City
December 2, 1955.

ARKANSAS MEDICAL SOCIETY

Little Rock, April, 1956

ARKANSAS ACADEMY OF GENERAL PRACTICE

Little Rock, April, 1956

INTERIM SESSION, A.M.A.

Boston, Mass.

November 28-December 1, 1955

SOUTHERN MEDICAL ASSOCIATION

Houston, November 14-17, 1955.

POST CONVENTION TOUR

Southern Medical Association has announced a tour to Mexico following its 1955 Annual Meeting in Houston on November 14-17.

Requiring only 10 days, the tour will leave Houston the afternoon of November 17 via Pan American Airways on a non-stop flight to Mexico City. After visiting Teotihuacan, Xochimilco, Cuernavaca, Taxco, and Acapulco, return to the United States is scheduled so that busy physicians may resume their practice on Monday, November 28.

For those who can spare the additional time, a week-long extension has been provided, which will feature the more rural and "off the beaten path" attractions in Mexico.

An adjourned session of the 1955 Annual Meeting will be held with local physicians in Mexico City on November 19, for which certificates of attendance will be issued.

Write directly to the headquarters office of the association in the Empire Building, Birmingham, or to International Travel Service, Inc., at the Palmer House, Chicago 3.

From the AMA NEWS SERVICES

NEW PAMPHLET SERIES IN SEX EDUCATION

A series of five new pamphlets covering all aspects of sex education has been prepared and is now being distributed by the National Education Association and the A.M.A. Bureau of Health Education.

The pamphlets, selling for 50 cents each or \$2.25 a set with discounts applying to quantities, were prepared by Marion O. Lerrigo, Ph. D., and Helen Southard, M.A., both of New York, with Milton J. E. Senn, M.D., New Haven, Conn., serving as medical consultant.

Titles of the new series and the period each covers follow: "Parents' Privilege," for parents of young children of pre-school and early school age; "A Story About You," for children in grades 4, 5, and 6; "Finding Yourself," for boys and girls of approximately junior high school age; "Learning About Love," for young people of both sexes, about 16 to 20 years of age; "Facts Aren't Enough," for adults who have any responsibility for children or youth that may create a need for an understanding of sex education.

Orders for one or more of the pamphlets may be sent to Mrs. Louise Goldman, Bureau of Health Education, American Medical Association, 535 North Dearborn St., Chicago 10, Ill.

CITE HEALTH HAZARDS OF CHEMICALS

The A.M.A. Committee on Toxicology has set out to acquaint the public with the possible dangers of many chemical products being used today in the home, on farms, and in industry.

It is estimated that there are a quarter of a million brand name chemical products on the market. All of them may be useful—but handled improperly they may become killers, cripples, and destroyers of property.

Understanding of the uses and the potential dangers of the wealth of products available is needed to prevent the estimated 3,300 accidental poison deaths which result each year from misuse of chemicals.

The array is so large and so many combinations of chemicals are possible that no complete catalogue of all available products has been made, the committee said.

As part of its campaign to spread information about these products and their hazards, the committee will sponsor a symposium on health hazards of chemicals December 29 before the Pharmacy Section at the annual meeting of the American Association for the Advancement of Science, in Atlanta, Ga.

Bernard Conley, Secretary of the A.M.A. Committee on Pesticides—which is co-sponsoring the discussion—will be moderator for the symposium. He said the purpose of the meeting is to interpret new knowledge of chemical products to scientists in various fields, so they in turn may use and spread the information.

FARM/CITY WEEK, OCTOBER 23-29, 1955

Each physician and his medical society is invited to plan and participate actively in Farm/City Week, October 23-29, a week-long series of events aimed at bringing about better understanding between rural and urban dwellers.

Under the sponsorship of the Farm-City Conference, an informal alliance of leaders in industry, agriculture, and the professions, Farm/City Week is hoped to be one of the most effective ventures in good citizenship ever undertaken.

The A.M.A., a Conference member, has already sent program plans and suggestions to all medical society officers. Kiwanis International has been selected as the coordinating agency, and local Kiwanis club officers have been advised of your invitation to participate in state and community programs.

Because Farm/City Week provides a splendid opportunity for the medical society to assert its civic leadership and to inform the public of its many services, the A.M.A. urges all physicians

and societies to get behind this program to help dramatize the mutual need for good relationships between town and country neighbors.

Health and medical care are of uppermost interest in this activity dedicated to urban and rural progress. Medical societies can add greatly to the success of the Week by developing health programs for city and farm groups, addressing civic organizations, participating in newspaper, radio and TV interviews, providing tours of medical facilities, and presenting vocational guidance programs in secondary schools. In addition, physicians, as members of the community, should be represented in the general observances of Farm/City Week.

Here is a spot where Arkansas physicians can do some good relations work. Films are available.

A.M.A. OFFERS NEW TV AIDS

Two new television "scripts-with-film" programs featuring current health education information on the eye and its functions will be released this fall by the A.M.A. Prepared with the cooperation of the A.M.A.'s Bureau of Health Education and the National Society for the Prevention of Blindness, these shows are designed so that a local physician can narrate while the film is thrown on the television screen.

The programs are: (1) "A Clear Picture"—which deals with the eye and its functions, includes a clever animated sequence employing a fresh orange, a glass lens and a piece of lipstick to show the structure of the eye; (2) "Wonderful Spectacle"—which describes the functions of glasses and lenses. The programs are so constructed that they can be used as separate 15-minute programs or together as a single 30-minute presentation. The film demonstrator is Dr. Brittain F. Payne of New York City, noted ophthalmologist.

Both films and accompanying scripts will be available about September 15 through the A.M.A TV Film Library. There is no charge to medical societies.

NEW PARKE, DAVIS MOVIE HELPS MEDICAL PROFESSION

Parke, Davis and Company, Detroit pharmaceutical firm, shortly will release a new movie, entitled "Going Our Way," which will be shown to public audiences, including civic and service clubs across the country. Prints of the 29-minute, colored movie will be available after October 1.

Eleven A.M.A. staff people were invited to a premiere showing in Chicago last week, and the

general feeling was that the movie was exceptionally well done.

It tells the story of medicine and pharmacy, and the central theme pinpoints the fact that there are good opportunities for service in medicine, pharmacy, research, and nursing.

Information regarding the movie can be obtained from Mr. Ralph G. Sickels, advertising director, Parke, Davis & Co., Detroit, Mich.

ANNOUNCEMENT

Physicians interested in presenting a scientific exhibit at the Annual Meeting of the Arkansas State Medical Society April 23-25, should write to: Lawrence M. Zell, 937 Donaghey Building, Little Rock.

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "Use of Radio-Active Isotopes in the Treatment and Investigation of Disease." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$350 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

DANGER!

Read Carefully

From the Washington Letter—

FOLSOM REAPPRAISING HEALTH PROGRAM FOR PRESIDENT

Secretary Marion B. Folsom disclosed August 24 that the Department of Health, Education, and Welfare is taking "a new look at the whole health program" and in particular the health bills that failed to pass the last session. Included in this category is the reinsurance proposal. On this bill, Mr. Folsom noted that the plan had been considered by two Congresses "and nothing has been done with it." On the House-passed bill for a national disability insurance program for covered workers 50 or older, the Secretary commented that "we can't ignore such legislation in any program we might prepare. We might not mention it specifically but we can't ignore it."

Mr. Folsom explained that HEW has to make a decision soon on health proposals in order to make recommendations to the President for possible inclusion in his program. He added: "We

have reached no conclusions. Our reconsideration does not mean that we will drop any of the proposals any more than it means that we may decide to stick by them exactly as they were."

The bill HR-7225 would finance all of the new benefits by increasing the Social Security tax on both employer and employee. . . . By 1975 each would be compelled to pay a tax of 4½%. . . . Actually, this means that the individual in 1975 will be forced to pay 9% of the first \$4,200 of his annual income for uncertain "benefits," because the employer must, of necessity, pass his share of the compulsory taxation on to the consumer. . . . Mrs. Hobby, who has retired as Secretary of the Department of Health, Education and Welfare, in her farewell appearance before the Senate Finance Committee on July 26th, urged the Committee to approach the revisions with great caution. . . . In arguing for a thorough investigation by the Committee, Mrs. Hobby contended the bill "raises many basic and complex issues." . . . She called particularly for a full investigation of the disability and women's retirement provisions. . . . She said that the system (Social Security) could lose its attractiveness, particularly for many self-employed persons, if additional cost items are added without the most careful evaluation of the benefits they confer. . . . Mrs. Hobby made an exceedingly significant point when she told the Committee that a self-employed person with a wife and two children who earns \$4,200 or less annually, would pay more Social Security taxes than the federal income tax imposed on him. . . . Representative Noah Mason (R., Ill.), a member of the House Ways and Means Committee, supported Mrs. Hobby's position that increased taxes could price Social Security out of existence when he stated: "The bill puts the Social Security system on a more unsound actuarial basis than even now and the Social Security system is bound to collapse when the burden becomes too heavy to bear."

—Newsletter, A.A.P.S., 1955.

"People like to learn about the things that can happen to their body, and about additional aids in keeping the human machine functioning at its optimum. Every physician should be a health educator, and health museums, and health fairs offer a wonderfully worth-while opportunity for all medical men and their wives to demonstrate that they are civic-minded, and to help raise the standards of health in their respective communities."—M. O. Rouse, president-elect, Texas Medical Society, From "Health Interest"—Texas State Journal of Medicine, August, 1955.

YOUR OPINION COUNTS!

. . . It was your opinions expressed insistently that convinced the Senate Finance Committee to wait until next year to hold full and complete hearings on HR-7225, Social Security revisions. . . . This atrocious measure was railroaded through the House of Representatives with no public hearings and only 40 minutes floor debate. . . . Senator Byrd, Chairman of the Senate Finance Committee, stated that he had received requests from 150 groups asking to be heard on the bill. . . . Sometimes it appears that Congress does not listen to the voices from back home. . . . This is not true—they do listen because your votes have the authority of hiring and firing them.

Arkansas

TRAVELING

And Clipping Bits Here and There

EDITORIALLY SPEAKING

From the Weekly Bulletin
(Jackson County [Mo.] Medical Society)
September 10, 1955

A great, good and wise king, who had grown old in the service of his country and realizing that his time was short, one day called his sons and his counselors to him and spoke to them as follows:

"My children and my beloved helpers: As you know I have ruled this country for long decades. Soon I will leave you. Before I go I wish to pose a problem. The solution of this problem is vital for the future of our people.

"As you know, I have always bowed to the will of my people when they were united in their requests or when the great majority wished something, even at times when I was sure that what they wanted was not always the best for their future good.

"You who are older than the rest remember that they first asked me to control their farms, to see that, if they raised more than we could eat, I would buy it and store it for future needs. In return they promised that they would permit me to tell them how much they could plant and what. I could not myself visit every farm, so I had to appoint others, men who needed work, to do this for me. They visited these farms and they soon had full control, because if my people did not do as they said, they could not sell what they grew to be stored.

"And then those in the cities and the factories came to me and said that I must set up rules as to how long each person could work and how little he could be paid, and I must also decree that only the members of the guilds could work in certain factories and stores. The young men who wished to work in these places must join the guilds. In return they promised to set up plans so that their own would be taken care of in sickness and in old age.

"But this was not enough, as it turned out. I was asked to take away from all people (more from the rich), monies in the form of taxes and set up funds to pay those who were out of work and those who were too old to work. Again I could not do this alone. Others were told to do this work and they had to decide how it should be done. They had to investigate and study each case, finding out all facts so that they could determine who should receive these monies and who should not.

"Lastly they came and asked that clinics and hospitals be set up by me, claiming that this would give all my people perfect and total security so that they would have no worries. I and those I appointed would be responsible for everything. This also I did.

"And now my good friends and children, here is the problem: How can I do all this through people whom I have appointed and still grant to my people their freedom of action, their freedom of choice of how to live their lives, their freedom of decision? This they no longer have.

"Since they have given to me all power over their lives, from the cradle to the grave, how can they be taught to think, to use initiative, to develop themselves, to be other than sheep who may be beguiled by more promises into following in the future some Judas goat who is only plotting their destruction?

"This is my problem: How may a people receive perfect security from those who govern them and yet maintain their freedom?"

—Wilse Robinson, Jr.

BRAIN WASHING—AMERICAN STYLE

Reprint from *The Bulletin*,

Columbus Academy of Medicine, March, 1955

Anyone who thinks brain washing is the patented or copyrighted exclusive product of those emissaries from Hell who operate behind the Iron and Bamboo Curtains had better take another look closer to home. He might be surprised to find that his erstwhile benefactors in the form of the ubiquitous Federal do-gooders

and hand-outers have developed some subtle techniques of their own along these lines.

All the reason and logic in the world seem to lose their force when opposed by the cold cash of Federal give-away programs. The farmer who is paid to limit his acreage and to guarantee his profit, who gets cheap electricity at the expense of millions of taxpayers, including not only himself but thousands of others too, is not apt to be unalterably and unequivocally opposed to Socialism as it applies to benefits he receives. The financially harassed soldier's wife is softened up for socialized medicine when the government pays her doctor bill. The subsidized tenant living in government housing at taxpayers' expense is prone to forget that he is one of those taxpayers or, if he thinks of it, he gloats over the fact that while non-subsidized tenants help to pay his rent, he doesn't help pay theirs.

The medical student who is educated at government expense—to be paid back later five times over out of his own income tax—is so grateful for the solution to a present problem that he can't be bothered about a bigger one in the future, nor can he clearly see any evil in government subsidies for medical schools.

The voluntarily unemployed living on a government dole, that many times supplements other family income, can't understand why some people are stupid enough to work for a living. The old age pensioner and recipients of social security, that in many instances cost him little or nothing, are disinclined to be so lacking in gratitude as to let their minds dwell on such matters as inflation, taxes, actuarial procedures, graft or the menace of Socialism.

We can laugh at the stupid brain washed Russian who is proud of his country that houses him in a pig pen, works him long hours for phony pay of negligible purchasing power and at the same time we lustily complain about income tax and other taxes as though they bore no relation whatever to the multitude of handouts we have learned to demand.

The government giveth and the government taketh away and blessed is Mrs. Hobby.

But what of those few recalcitrants, those people of initiative and independence and determination, are they to be allowed to undermine the morale of the whole body politic? Why should we handle them with kid gloves? If they haven't the good sense and decency to yield to gentle philanthropic brain washing give 'em the water cure—drive a few bamboo splinters under their finger nails—turpentine their eyeballs, let's show 'em we know what's good for them and that we mean business.

Intemperate, you say? Intemperate, indeed! Fortunately we have cooler heads in our Welfare Dept. There will be no bamboo splinters—instead our State Welfare Department had sued the Harrison County Commissioners to **force** them to accept Federal funds that they claim they neither need nor want. Here we have the spectacle of the County Commissioners being forced to use public funds to hire lawyers to defend themselves against the demand that they accept a handout of Federal funds that was extracted from them originally in the form of taxes. This demand is made by a public agency and prosecuted by the public employed Attorney General who, of course, is paid in part by the citizens of Harrison County.

The Federal government was holding as hostages 87 of our 88 counties and threatening to cut off their funds (in the best held-for ransom tradition) if Harrison County failed to accede to their demands. Shades of the Barbary Pirates. What would Mr. Hammar skjold say? Fortunately we'll be spared his intervention. The Supreme Court of Ohio has ridden to the rescue and Harrison County has been bested to the glory of the Welfare State.

But that's not all, a strange and depressing complacency seems to have settled like a brain washing fog over the minds and spirits of a large segment of our profession. Members formerly articulate and active in defense of their rights have become tongue tied, apathetic, and stingy. With Eisenhower in the White House, Malenkov in the dog house, and Wayne Morse back in the Democratic party, almost everyone seems to be convinced that we can now safely and with impunity take leave of our senses. And they may be right. Maybe we can take leave of our senses. Maybe this country no longer needs the services of the medical profession. Not when the great white Father in Washington is a medical man of such skill that he can perform a complete enterocolectomy on better than half of the doctors in this country without even leaving a scar. Using neither scalpel nor hemostat, and with only hypnosis for an anesthetic and a few disarming cliches for his tools, the President has succeeded in separating the American medical profession from its guts and should his nurse, Mrs. Hobby, take a notion to do so, there is little doubt but that she could do an equally good job on its backbone.

It is difficult to question the sincerity or integrity of the smiling, gracious man who has taken up the heavy burden of the Presidency but it becomes increasingly apparent that he is

deceitfully and banefully advised by a clique of Fifth Columnists who have captured the Republican party from within, wearing no more disguise than a campaign button and having no more feeling for the principles of the Republican platform than a snake has for the hapless bird it is about to devour.

The simple inescapable truth is that far from reversing the leftward trend of the New Deal and the Fair Deal this administration has given it even greater impetus and a thin and transparent cloak of respectability besides.

The President favors Federal aid for schools, 70,000 public housing units, Federal reinsurance, expansion of Social Security, a 50 billion dollar highway program, Federal aid to medical education, Federal funds for clinics, and almost limitless funds for foreign handouts. He says that he will continue to reject socialized medicine and then proceeds to demand legislation that must inevitably lead to that very end.

Call it what you will, dress it up in any kind of deceitful language that you like, socialism is socialism and Mr. Eisenhower has recommended legislation that will put the government into still more businesses, create still more bureaucracies, run up even bigger debts and carry us further leftward than we have ever been.

Mrs. Hobby, for her part, is on the make. With the Cabinet status that Oscar Ewing was never able to attain, this renegade Democrat is out to outdo Harry Hopkins in "spend and spend" and before she's finished the medical profession may be harboring a warm nostalgic feeling for her predecessor.

By the staff of Aesculapias my friends, we'd better throw off our lethargy, rejoin our allies, support our like-minded friends, and fight for our rights and the good of the country.

—Charles W. Pavey, M.D.

WORTH REPEATING AND REMEMBERING

"I believe that the greatest error of our time is that we have given to political rulers the coercive power to make us conform to THEIR idea of what is good for US. . . . I believe that unless each one of us rekindles his faith in individual freedom and in individual moral responsibility to his God and to his neighbor, we will surely lose all that is precious in our way of living."—Admiral Ben Moreell.

"If ever the human race is raised to its highest practicable level intellectually, morally and physically, the science of medicine will perform that service."—Rene Descartes.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

PROBLEM OF THE ASYMPTOMATIC PULMONARY LESION

By R. DREW MILLER, M.D., *The Journal Lancet*, March, 1955

A 67-year-old clothing salesman registered at the Mayo Clinic on November 11, 1953, for evaluation of an asymptomatic X-ray shadow in the field of the upper part of the left lung. The abnormal shadow had been discovered in June, 1949, in a routine roentgenologic survey. Follow-up roentgenograms were made in the next few months. Apparently little change occurred in the roentgenologic appearance of the lesion until August, 1951. In December, 1951, the patient had a short episode of substernal pressure-type which was relieved by pills and an injection. No apparent change was noted in the electrocardiogram to indicate localized myocardial injury. On January 23, 1952, he entered his local tuberculosis sanatorium and began to receive antimicrobial therapy with streptomycin and para-aminosalicylic acid. Use of the para-aminosalicylic acid (PAS) was discontinued after four months, but the streptomycin was given for two more months. The roentgenologic appearance of the lesion showed little change during the six months of treatment, and the patient was dismissed for roentgenologic follow-up studies on an outpatient basis. The patient was not aware of any positive results of procedures for the detection of tubercle bacilli by smear, culture, or inoculation of guinea pigs with specimens of the sputum or with gastric washings. In September, 1953, he had noted slight fever and cough of a few days' duration, relieved by injections of penicillin.

In October, 1953, a follow-up roentgenogram of the thorax showed possible slight enlargement of the shadow under observation. Further investigation was recommended. There were no unusual symptoms at this time, however.

The patient was found to be an asthenic white man weighing 117 pounds, and 67 inches in height. The blood pressure was 140 systolic and 80 diastolic, in millimeters of mercury. The cardiac rhythm was regular and there were no significant murmurs. Other than slight diminution of breath sounds and occasional soft rales over the left posterolateral aspect of the thorax, the findings were not significant. Lymph nodes were not enlarged.

Urinalysis, determination of hemoglobin, leukocyte count, and determination of the blood urea gave results within normal limits. The sedimentation rate was 15 mm. in one hour by the Westergren method. Result of the Kline test was negative. A tuberculin test, in which 0.0001 mg. of purified protein derivative was used, was reported as giving a negative result. A second injection of 0.005 mg. of purified protein derivative was reported to have produced a positive reaction after forty-eight hours. An electrocardiogram showed only left axis deviation. Examination of the sputum, bronchial smears, and bronchial washings for malignant cells and acid-fast bacilli gave negative results.

A roentgenogram of the thorax showed a rather extensive lesion on the left at the level of the first and second anterior interspaces. Tomograms of the area showed no definite cavitation. The serial roentgenograms of the thorax made in the patient's home town, when reviewed, showed very slight enlargement of the shadow over the two-and-one-half year period. Bronchoscopy revealed no gross abnormalities.

Because of the indeterminate nature of the lesion after clinical study and observation, left thoracotomy was advised. A grade three adenocarcinoma of the posterior segment of the upper lobe of the left lung was found at operation, with no involvement of the hilar nodes. Left pneumonectomy was performed. The patient made an uneventful recovery.

Follow-up reports from the patient's local physician indicated that symptoms of cerebral metastasis appeared. The patient died on June 5, 1954. A large metastatic lesion of the right cerebral hemisphere was found at necropsy.

The value of survey roentgenograms, which is widely appreciated among the laity as well as within the medical profession, is again demonstrated in this case. The case further points out the difficulty so often encountered in making a clinical diagnosis after an asymptomatic lesion is discovered. The lesion located peripherally in the field of the upper part of the left lung had char-

acteristics of either a chronic inflammatory process or a neoplasm. Although it was possible to detect the abnormality by means of the roentgenogram, this did not provide the etiologic diagnosis. Laminated calcium, diagnostic of a granulomatous process, was not evident in any of the serial thoracic roentgenograms of this patient. Even tomograms, made just before operation, did not demonstrate calcium. Thus, a malignant neoplasm could not be ruled out from a roentgenologic standpoint. The value and limitations of roentgenologic technics in the detection of asymptomatic lesions have been reviewed by Good and associates. Serial roentgenograms showed little change in the abnormal shadow. Although failure of such a shadow to change might suggest that the lesion thus depicted is benign, this case demonstrates how a bronchogenic carcinoma, particularly an adenocarcinoma, may show little change over a period of months or even years.

The failure of previous bacteriologic studies by home physicians to demonstrate tubercle bacilli in the patient's sputum or gastric washings cast doubt upon the clinical diagnosis of pulmonary tuberculosis. Furthermore, failure of the shadow to regress during combined chemotherapy should lead to further questioning of the previous clinical diagnosis. The skin tests indicated that the patient previously had been infected with tubercle bacilli and probably also *Histoplasma capsulatum*, but additional bacteriologic studies had failed to show that the pulmonary lesion was related etiologically to the cutaneous reactions. In this case a clinical diagnosis could not be made by the usual laboratory methods, and thoracotomy became necessary. The incidence of malignant lesions among asymptomatic circumscribed pulmonary lesions has been pointed out by Harrington.

The patient's ultimate clinical course illustrates the serious complications which often follow the discovery of bronchogenic carcinoma, even though the hilar nodes were not involved. Tinney and Moersch found symptoms referable to the nervous system in 12 per cent of 448 cases of carcinoma of the lung. In 4 per cent of the entire series, the neurologic symptoms represented the presenting complaint. King and Ford, in reviewing 100 cases of metastasis to the central nervous system from carcinoma of the lung, concluded that these types of metastasis occur early and frequently. This further demonstrates the importance of early diagnosis and treatment of asymptomatic lesions of the lung.

Obituary

WILLIAM B. GOULD, Glenwood, 82, died suddenly in his office August 2, 1955. He was the oldest practicing physician in Southwest Arkansas, having been a practicing physician in Pike County for more than half a century.

After receiving his license in 1894, Dr. Gould first entered the practice of medicine at Bowen, Pike County, where he remained for two years. He came to Glenwood in 1910. Since then he had been actively engaged in his profession, and the operator of the Gould Drug Store which was opened in 1922.

He was a member of the Glenwood Masonic Lodge, and was honored as a 40-year member four years ago. He served as postmaster of Glenwood from 1914 until 1922. He was a member of the Board of Stewards of the Methodist Church for 50 years. He was a member of the American Medical Association, Arkansas Medical Association, and the Pike County Medical Society. He served as president of the Bank of Glenwood, and the Glenwood board of education for a number of years.

He married Miss Nora Johnson who survives, in 1899. Three children were reared by them. He is also survived by six grandchildren, one great-grandson, and a brother.

Funeral services were held at the Methodist Church. Burial was in Glenwood Cemetery.

STEPHEN COKE JOHNSON, Kingsland, aged 77, died August 24 at the Warren hospital where he had been removed a few days previously.

A native of Cleveland County, Dr. Johnson was the son of the late DeWitt and Dora Harrison Johnson, and was born near Kingsland. He was a graduate of Hendrix College, and the University of Arkansas School of Medicine.

For a while Dr. Johnson served as county health officer. Dr. Johnson was a member of the Methodist Church, and the Arkansas Medical Society.

Surviving him are his wife, the former Miss Rachel Allen; two daughters, and five grandchildren.

Funeral services were held from the Kingsland Methodist Church. Burial was in the Kingsland Cemetery.

PERSONALS AND NEWS ITEMS

Carl L. Wilson and Morton Wilson of Fort Smith presented a paper entitled "Urological Pathology Mimicking Intra-Abdominal Conditions" at the Southwestern Surgical Congress in Oklahoma City September 5th.

James H. Growdon and Robert M. Stainton of Little Rock presented a paper entitled "Acute Perforated Peptic Ulcer—An Analysis of 90 Cases" at the Southwestern Surgical Congress in Oklahoma City September 7th.

E. A. Mendelsohn, radiologist, Fort Smith, has been authorized by the Atomic Energy Commission to use Cobalt 60 Teletherapy equipment.

Donald Loveless addressed the Booneville Lions' Club in August.

Jack Keeling, Little Rock, is in New Orleans for post-graduate work in the Ochsner Clinic Foundation.

The "G. G. Woods Story" is featured in the August 11 number of the Greenwood Democrat. It pictures his more than fifty years of general practice in his community.

Paul Wright assumed direction of the Izard County Memorial Hospital at Melbourne, August 1st.

There is plenty of pride in the following announcement:

Harry E. Murry, Texarkana, announces the association of his son, John Warren Murry, in the practice of general surgery.

The **Journal** extends its congratulations to both.

Among those registered at the Southwestern Surgical Society which met in Kansas City September 5-7 were: John W. Dorman and Friedman Sisco, Springdale; M. C. Hawkins, Searcy, who was elected Councilor from Arkansas, and Fred H. Krock, Fort Smith, who was elected Vice President of the Society.

C. C. Long, Ozark, attended the officers' conference of the American Academy of General Practice in Kansas City early in September.

James H. Growdon, Little Rock, was guest speaker at the Kansas City Southwest Clinical Society meeting on October 4, 5, 6. He gave three lectures at the meeting.

H. K. Baldridge, Mountain Home, has moved to Heber Springs.

Harold Kelling is doing specialty work in general surgery in New Orleans.

B. N. Saltzman, Mountain Home, has announced the addition of eight rooms to his clinic to be completed this fall.

John E. Laman is completing a suite of offices on South Main St. in Little Rock in October.

R. B. Robins, Camden, addressed the Arkansas Association of Medical Librarians at their meeting in Little Rock August 18-19.

S. Wright Hawkins, Fort Smith, was elected a member of the local school board in March.

E. L. Milner announces the opening of his office for the practice of otorhinolaryngology and endoscopy in Little Rock.

A new clinic-office building is being planned for Conway. Edwin L. Dunaway, C. A. Archer, Jr., and John W. Sneed, Jr., are the prime movers in the event and they expect to be in their new quarters this fall.

J. W. Ryburn, Pocahontas, was honored on the occasion of his 80th birthday by his fellow townsmen August 24. A "surprise" party with many gifts to the octogenarian was held to also celebrate his regaining his health after some months spent in a Jonesboro hospital.

Contributors to the American Medical Education Foundation from the state of Arkansas during the month of August, 1955, were:

Cal D. Gunter, Siloam Springs.

James D. Huskins, Siloam Springs.

J. Harry Hayes, Little Rock, addressed the Suwannee Valley District Medical Society (Florida) August the 16th. The subject being "**Diagnosis and Treatment of Thyroid Disorders.**"

Irving J. Spitzberg, Little Rock, was appointed a few weeks ago as the Director of Nurse Training for the State of Arkansas for the Forty and Eight Grand Voiture of Arkansas by Dr. J. Lamey, the National Director of Nurse Training for that organization.

He was also recently elected a Commander of M. M. Eberts Post No. 1, American Legion.

R. B. Robins, Camden, has recently been appointed by Walter Alvarez, Editor of **Modern Medicine**, to represent General Practice on that publication's editorial board.

James G. Stuckey opened his office in Little Rock in August for the practice of plastic surgery.

W. J. B. Williams has returned to Cotton Plant after 2 years absence, and is erecting new offices which he will occupy for a general practice.

Swan B. Moss and Robert McDonald have purchased the Memorial Clinic at McGehee, and will operate it together after October first. Dr. McDonald moves from Eudora.

John D. Olson, Fort Smith, and Mrs. Olson have returned from a two-month trip to Europe where he attended the International Society of Surgeons in Denmark last July.

Roy E. Schirmer, Fort Smith, was made an Associate Fellow of the American College of Allergists at a recent meeting in Chicago.

PROCEEDINGS OF SOCIETIES

Felix N. Ruthledge, Houston, Texas, was guest surgeon at a closed circuit TV program presented by the Bowie-Miller Counties Tumor Clinic recently. William Derrick was the guest anaesthetist. W. B. Harrell, Texarkana, Chief of Staff at St. Michael's Hospital, presided at the meeting.

The Craighead-Poinsett Medical Society met Sept. 7th at the Hotel Noble, Jonesboro. The program follows:

"Clinical and Radiological Aspects of Ureteral Stone"—R. C. Hooper and E. M. Cooper, Jonesboro.

State President L. H. McDaniel mapped out plans for the coming year. The Ladies Auxiliary met also.

J. H. McCurry, Secretary.

The Ouachita County Medical Society met in regular dinner session at the Camden Hotel Thursday evening, September 1. Program was as follows:

"Dyspnea"—Richard Ebert, Professor of Medicine, University of Arkansas School of Medicine.

"Acute Renal Failure"—Ben I. Heller, Associate Professor of Medicine, University of Arkansas School of Medicine.

R. B. Robins, Secretary.

WOMEN'S AUXILIARY NEWS

Following the dinner served to the Craighead-Poinsett County Medical Society and Auxiliary on the evening of September 7th, at the Hotel Noble, the Auxiliary met for its monthly business session and program with the president, Mrs. A. J. Forestiere presiding. After routine business had been transacted, Mrs. John Gray, our state president, made an informative talk on "The American Medical Education Foundation."

The Woman's Auxiliary of the Columbia County Medical Society made two hundred sandwiches for lunches served to the patients at the Crippled Children's Clinic held in Magnolia.

BOOK REVIEWS

The Practice of Dynamic Psychiatry: Jules H. Masserman, M. D., Professor of Neurology and Psychiatry, Northwestern University, Chicago. Pp. 790. 1955. W. B. Saunders Co., Philadelphia. \$12.00.

"The Practice of Dynamic Psychiatry" is a brilliant attempt by a well-qualified individual to bring to those interested in psychiatry a text comprehensive enough to be useful to the psychiatrist, yet written in such an understandable fashion as to make it extremely valuable to the student of psychiatry or the general practitioner who must, by necessity, deal with both normal and abnormal conduct. It is believed, however, that the book will be found most useful to students and general practitioners.

The author divides the book into five essential parts. Part I deals with the psychiatric interview, the problems brought out during the questioning; Parts II and III describe and group various behavior disorders, and offers numerous case histories illustrating the various clinical syndromes; Part IV presents the (Theoretical) philosophical background for various concepts of psychiatry; Part V starts with a rather comprehensive history of psychotherapy, and leads up to the modern therapeutic techniques.

The book is quite readable, well organized, and has the unique feature of having well-placed examples distributed throughout its length to establish pertinent points.

Chas. N. Tarkington.

Pathology for the Surgeon: William Boyd, M.D. Edin., Dipl. Psychiat, Edin., F. R. C. S., Canada. Lecturer on the Humanities in Medicine, The University of Toronto, Visiting Professor of Pathology, The University of Alabama. 7th Edition. Pp. 737. Illustrated. 1955. \$12.50.

With a change in name Author Boyd signifies that his book is entirely rewritten, brought up to date and a text worthy of study and comment, which it is. The clear lucid style, typically Boyd, is still there. This pioneer was, and is, one of the first to make pathology readable to the average physician and this edition follows that tradition.

The text has been rearranged in line with the medicine of today. The space devoted to the virus and Rickettsial diseases now occupies much more than that allotted to syphilis. "Pathology of the Living" and its treatment make this a book more desirable to the surgeon, the general practitioner and the internist than to the pathologist. The illustrations are practically all new and revealing. The pages are printed in two columns for easy reading. The

index is complete. The chapter on The General Pathology of Tumors is perhaps the most concise and finely written of the text. Without being too long and detailed, a large number of reference notes are given at the chapter's end, where supplementary material can be found. It is a new book, from a master teacher, entirely rewritten, but still Boyd.

The Physician and the Law: Rowland H. Long. Lecturer in Forensic Medicine, New York University Post Graduate Medical School. Pp. 284. August 15, 1955. Medical Dept., Appleton-Century-Crofts, New York, N. Y. \$5.75.

This text is written in a concise didactic form and carefully avoids repetition and verbosity. The legal training of the author is in evidence. The book could serve as a text in medical school, as the source of a panel discussion before a medical society, and as an authoritative reference for a busy physician. The material is well selected, the diction is excellent. Practically every phase of the legal duties that may be required of a practitioner who has legal problems is discussed. To name a few places which might controversy, the author has included chapters on autopsy, on adoptions and an extensive chapter on the physician and criminal law—including: abortions, acts while intoxicated, and contraception.

Within its covers is a wealth of valuable material made readily accessible by a complete index and a glossary of legal terms likely to be met in medico-legal controversies.

Counselling in Medical Genetics: Sheldon C. Reed. Director Dight Institute for Human Genetics, University of Minnesota. Pp. 268. 1955. W. B. Saunders Company Philadelphia. \$4.00.

What happens when the distraught parents ask the physician what chances their next child has of being a mongoloid? Most practitioners evade the question or frankly admit they don't know.

Mr. Reed's new text serves as an excellent reference work to accurately face and answer such problems. He has chapters on Disputed Paternity, Blood Diseases and Congenital Heart Disease. The effects of consanguinity are discussed and in many cases specific examples are given. An appendix with many specific disease listings and their genetic connection is presented as well as an extensive bibliography and index.

This is a reference book for a man in practice, and a compendium of valuable information which a physician can put his thumb on quickly. Its use will save many an embarrassing moment.

While some physicians were doing a legislative Rip van Winkle, last year the 83rd Congress enacted Public Law 482 which is an expanded Hill-Burton Act. . . . The law provides for the establishment of diagnostic and treatment centers. . . . Centers for assembly line medical care by panels of salaried doctors long has been one of the most sought-after objectives of the socializers. . . . We are pleased to credit the Iowa State Medical Society with being the first state organization to realize the real dangers in "diagnostic and treatment centers." . . . The Executive Council of the Iowa State Medical

Society on January 26, 1955, rejected this part of the Hill-Burton Act. . . . Among other valid reasons for rejecting the Act, the Council stated that it had found no need for additional diagnostic or treatment service, and that the proposal to establish hospital diagnostic-treatment clinics is but another form of socialized medicine whereby the hospital, financed by the government, will assume the dominant role in diagnosing and treating illnesses.

The expanded Hill-Burton Act provides that applicants for its benefits must be either (1) a state, political subdivision, or public agency, or (2) a corporation, or an association which owns and operates a non-profit hospital. . . . In view of the fact the federal government would provide funds to finance the centers on a state matching basis, it is necessary for state legislatures to pass enabling legislation. . . . Enabling legislation to permit Iowa to accept all provisions of the Act was introduced in the Iowa State Legislature on February 9, 1955. . . . This shows how rapidly local socialists are acting to inaugurate this type of socialized medicine at the local levels. . . . We recommend that state medical associations check immediately to determine whether or not enabling legislation has been introduced in their respective legislatures. . . . Legislation to implement the program at the state level and to provide state matching funds, should be opposed vigorously.—From the Newsletter, A.A.P.S., 1955.



..... The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

November, 1955

No. 6

WHAT'S NEW IN OBSTETRICS AND GYNECOLOGY*

W. D. THORNTON, Texarkana

In presenting "What's New in Obstetrics and Gynecology," I will endeavor to inform you of the recent developments in Obstetrics and Gynecology as reported in the literature. Some of the material to be presented will not be new to all of you. I only hope that some of it is new and interesting to most of you.

I think it might be well to begin with some of the advancements in the field of obstetrics. Arthur Weinberg¹ has estimated the degree and frequency of pelvic expansion during pregnancy and labor by studying 171 pregnant patients who had X-ray pelvimetry by the same technic 10 days before term of two or more pregnancies. In 150 women studied at the end of the first two pregnancies, average increase in the greatest transverse diameter of the inlet was 3.4 mm. This is significant clinically, because even in extreme degrees of molding of the infant's head it is doubtful that more than a 3 mm. reduction in any diameter is achieved. Average increase of interspinal diameter between nulliparous and primiparous patients at term in 144 instances was 3.7 mm.

A question repeatedly raised concerns the value of routine X-ray pelvimetry. Marck and Melamed² believe that routine screening of primigravidas by X-ray pelvimetry in the antepartum period is not essential for the management of these patients. Without integration with the clinical features of labor, X-ray pelvimetry may prove misleading in the determination of obstetric prognosis and choice of operative procedures when indicated. However, for many patients, X-ray pelvimetry near term is good for psychological reasons.

A critical evaluation of the pregnancy test for prenatal sex determination by the technic of Rapp and Richardson was made by Posner³ and his associates. The saliva of 200 women who were pregnant six to seven months was studied—the accuracy in predicting males was 73 per cent and in females 56 per cent. These authors maintain

that the accuracy of prediction so approximates mere chance that they do not feel this test is of much value in its present state. Also Mengert⁴ and his associates found no evidence that accuracy of prediction of sex was any better in their 1,027 Rapp-Richardson series than might have been achieved in a comparable series by chance alone. Therefore, the tests must be regarded as inaccurate, unreliable and not clinically useful.

To the multitude of causes of habitual abortion, Greenblatt⁵ adds still another, namely, increased capillary fragility, possibly caused by vitamin P deficiency. His regimen of therapy includes bed rest, thyroid medication and polyvitamin, estrogen and progesterone therapy to which are added hesperidin with vitamin C. He suggests that correction of abnormal capillary fragility in habitual aborters decreases the possibility of retroplacental hemorrhage.

Russell R. DeAlvarez⁶ and associates have studied the patterns of sodium and water metabolism during ion exchange treatment of pre-eclamptic toxemia. The object of ion exchange resin therapy is to increase the total excretion of sodium by increasing the fecal excretion of sodium. Twenty-three pre-eclamptic patients were given 48 gm. of Carboresin daily for four days and 43 patients 96 gm. daily for four days. All were followed for four additional days after the medication was given, and some patients were given an additional four days of drug therapy. All were on a low sodium diet and received 4,000 cc. of fluids daily. Sodium was the principal ion studied because an excess sodium is the primary factor in edema production. The Carboresin therapy reduced the urine sodium markedly both during and for a few days after administration. The patients went into a negative sodium balance. The usual normal distribution of sodium excretion is 5 per cent in the stool and 95 per cent in the urine. During Carboresin therapy, it is 72 per cent in the stool and 28 per cent in the urine. Following Carboresin administration, there is a marked reduction in total sodium excretion, resulting in a

*Read before the Seventy-ninth Annual Session, Arkansas Medical Society, Hot Springs, June 1, 1955.

positive balance with retention of 90 per cent of the sodium ingested. The Carboresin had no significant effect on water balance, all patients being in positive balance during the study. It is concluded that cation-anion exchange resins are valuable adjuncts in the treatment of pre-eclampsia.

Elective induction of labor has a useful place in obstetrics, with advantages to both patient and physician, and should no longer need to be done secretly or with apologies. Erving⁷ reported that at Elizabeth Steel Magee Hospital, Pittsburgh, in 17 months there were 600 elective inductions of labor by rupture of the membranes, constituting 6.8 per cent of all deliveries. In Erving's private practice, about 14 per cent of the patients had elective inductions. No one will argue about necessary induction of labor, as, for example, toxemia of pregnancy which does not improve with conservative therapy, some cases of diabetes with a large baby and selected cases of erythroblastosis. However, there is considerable controversy about elective inductions for the convenience of either the doctor or the patient. The criteria for rupturing the membranes for elective induction of labor are: (1) Patient at or near term; (2) Pelvis normal; (3) Presenting part preferable a vertex; (4) Cervix at least 50 per cent effaced and at least $\frac{1}{2}$ cm. dilated.

In the past few years there has been a widespread increased tendency to rupture the membranes for induction of labor, elective or otherwise. This has brought protests from some obstetricians who say this interferes with nature. The opponents of artificial rupture maintain that it brings about all the evils of dry labor; prolonged difficult labor, cerebral damage, a higher neonatal mortality and more maternal injuries. However, impartial analysis of the results of artificial rupture fails to disclose these dangers. In fact, when artificial rupture of the membranes is carried out properly, labor is generally shorter than usual, operative intervention is not increased, the cervix is not damaged more often than normally, morbidity is not increased, nor is neonatal mortality. Therefore, the bag of water is not as important in the mechanism of labor as was formerly believed. This does not mean that dry labor is without risk. One must differentiate between artificial rupture of the membranes and spontaneous rupture of the bag of water before the onset of labor. In the latter condition some abnormality is probably responsible for the rupture, and this disturbance, rather than the rupture itself, may be the cause of the evil consequences sometimes observed in dry labor.

Toaff and Eckerling⁸ report results with gastro-

intestinal administration of oxygen in asphyxia of the newborn in 7 prematures and 38 full term newborn infants. In 43, the asphyxia was graded as moderate or severe by Flagg's classification. Two No. 10 catheters were gently pushed into the stomach and a stream of $\frac{2}{3}$ L. of oxygen was fed into one of them. The stomach and intestines were distended. The outflow of oxygen from the stomach was controlled by immersion of the upper end of the second catheter in water. Use of oxygen was discontinued only when respiration became free and rhythmic, cardiac action was normal, color of the skin and mucous membranes became pink or red and muscular tone returned. Gastrointestinal administration of oxygen is a satisfactory procedure because it is simple and the lungs cannot be damaged.

With the establishment of the etiology of erythroblastosis and with the knowledge that the antigenic factor is attached to red blood corpuscles, Mengert and associates have shown experimentally that there is placental transmission of erythrocytes.⁹ With the aid of washed donor erythrocytes tagged with Fe^{59} and injected into pregnant women, they were able to demonstrate significant amounts of radioactivity in the blood of their fetuses, in 25 of 29 subjects. Two pregnant women at term were given blood from donors with sickling trait but without sickle-cell anemia. Sickle cells were thought to be demonstrated in the blood of the fetuses. On the basis of these experiments, a reduction of placental transfer of maternal erythrocytes would lead to a reduced disease incidence.

A simple and accurate means of early diagnosis of pregnancy continues to be an intriguing problem. Farris¹⁰ has developed a method of early diagnosis of pregnancy by matching prepared colors with the bluish color of the cervix seen early in pregnancy. The object of the test is to match the color of the cervix as closely as possible with that of known standards—precise matching being unnecessary in order to diagnose the existence of pregnancy. The cervical color test may be diagnostic of pregnancy shortly after the missed period, as early as cycle day 30. Investigations are under way to determine the influence of conditions other than pregnancy on the color of the cervical mucosa.

The obstetrician who has completed delivery of a breech presentation with the exception of the aftercoming head, finds himself in a position similar to that of the anatomist dissecting a hip, trying to remove a femoral head from the acetabulum. In both instances a rounded mass with a handle is retained in a snugly fitting socket,

largely by suction. Therefore, Rush¹¹ has recommended the following procedure for delivery of the aftercoming head. With the body of the baby held upward by the ankles with the left hand, the fingers of the right hand are passed gently between the baby's head and the wall of the vagina on the right. The fingers are moved around the head to break as much of the air seal as possible and to accumulate an air bubble deep to the head. The infant's ankles are then grasped in the right hand and the maneuvers are repeated with the left hand. Apparently by the breaking of the air seal around the head and by the formation of an air bubble inside the birth canal, the final phase of delivery is much simplified.

There is increasing evidence in the literature that Cortisone has little to recommend its administration to the Rh negative sensitized mother. DeCosta, Gerbie and Potter¹² found that of 45 babies born to mothers so treated, 18 died. Those that survived might well owe their existence to prompt and adequate blood replacement. Even without Cortisone therapy, a successful outcome of pregnancy can be expected in about 35 per cent of Rh immunized mothers who have previously been delivered of a stillborn erythroblastic fetus or of an erythroblastic baby that died. If the Rh negative babies are eliminated from consideration, infant survival can be expected in about 24 per cent if prompt and adequate treatment is given.

Davies¹³ described congenital retroversion of the uterus due to abnormally placed sigmoid colon. The colon may be displaced to the region of the left round ligament and be intimately attached to it. The left tube and ovary are thereby displaced and compressed by the overhanging colon, and attachment of the round ligament to the sigmoid destroys its function as a uterine stabilizer. Consequently, there is retrocession and rotation of the uterine fundus, with resultant vascular stasis due to compression and angulation of the veins. Because of abnormal attachment of the gastrointestinal and reproductive tracts, symptoms referable to both systems are present. Treatment is at first medical. Whenever the abdomen is opened for relief of a symptomatic fixed retroversion of the uterus, it is not enough to perform a round ligament fixation operation without determining whether an abnormally placed sigmoid may be a factor.

Payne¹⁴ reports on the use of X-ray therapy in the treatment of female infertility. He used low dosage X-ray therapy in treatment of 61 infertile women with ovarian dysfunction. Improvement in menstruation occurred in 77 per cent, and 44

per cent conceived. Results have been best in young women with secondary amenorrhea. Women past the age of 35 generally do not respond. The mechanism of action of low dosage X-ray is obscure but it is probably one of increased vascularity in the irradiated organ such as is seen in the erythema of the skin following irradiation. Candidates for low dosage irradiation should be carefully selected and X-rays used only when all other methods have failed.

Enzymatic debridement of pelvic abscesses that are accessible through the posterior fornix of the vagina was investigated by Collins¹⁵ and his associates. A refined, dried filtrate (Varidase) containing 100,000 units of Streptokinase and 25,000 units of Streptodornase (diluted at the time of use with 10-20 cc. normal saline) was injected into the abscess cavity after diagnostic cul-de-sac puncture. About 5-30 cc. of exudate was withdrawn, depending on the size and tension of the mass, and 4-20 cc. Varidase solution was instilled through the same needle while it was still in place. The amount of Varidase solution was never larger than that of the removed exudate. About 15-24 hours later, colpotomy was performed and a 1 cm. gall bladder T tube was inserted in the cavity. Varidase (1 ampule in 20 cc. normal saline) was instilled through the T tube daily for four days, then the colpotomy tube was removed. The average hospital stay for patients with cul-de-sac abscesses treated with Varidase was 9.25 days; for controls, 15.08 days. Postoperative time was reduced from an average of 11.7 to 4.6 days. Morbidity was greatly decreased in the treated group. The authors conclude that Varidase is safe and effective in treatment of pelvic abscesses.

Although vulvar lesions are relatively uncommon in our every day practice, they include many conditions for which vulvectomy is the treatment of choice. Marback and Schinfeld¹⁶ have presented a new technic for vulvectomy. This entails the use of the high frequency electrosurgical current. The advantages of this technic over other methods are given as (1) In conjunction with triple sulfa cream, primary healing is the rule, not the exception, (2) The time required for operating is short; less anesthesia is used, morbidity is lower, loss of blood is less, and shock is prevented, (3) The patient's immediate post operative course is more comfortable; decrease in the amount of local pain is characteristic of high frequency incisional wounds, and the softer scar is more comfortable in the remote post operative period.

Albert Decker and Wayne H. Decker¹⁷ have reported on a new tubal function test to determine the ability of the patent tubes to transport

the ovum. The test is performed by depositing a sterile suspension of starch over the fibria or the surface of the ovary by means of the operating culdascop or by cul-de-sac needling. The suspension may also be introduced at laporatomy. In 24 hours, cervical mucus is removed and stained for two minutes with iodine. A positive results is obtained when the stained starch granules are recognized by their characteristic shape and dark blue stain. Normal patent tubes will regularly transfer starch granules in 24 hours, regardless of the day of the cycle.

The incidence of monilial vaginitis has increased over the past few years and to some extent this has been attributed to the increased and widespread use of antibiotics. Hendricksen¹⁸ and his associates have reported on the use of Asterol dihydrochloride in the treatment of monilial vaginitis. A 5 per cent Asterol vaginal cream was used and the patients were instructed to apply this cream with a plunger type vaginal applicator each night. Of the 65 patients studied 83.1 per cent were "clinically cured"; 6.2 per cent were improved; 10.7 per cent received no benefit. The authors concluded that Asterol is a useful drug in vaginal moniliasis. Its value is enhanced by its freedom from objectionable color or odor.

Reserpine has held a prominent place in the literature for the past two years. Dr. Greenblatt¹⁹ has studied the effects of Reserpine in a series of women with certain gynecologic disorders, including premenstrual tension. Of several dosage schedules tried, he found 0.25 mg. t.i.d. to be preferable and this dosage was administered for ten days before the expected onset of menses. He found that the tension was greatly lessened, however, those with premenstrual edema complained of increased edema.

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The University of Kansas School of Medicine announces its Eleventh Annual Postgraduate Refresher Course in Surgery, to be offered January 16 to 19, 1956, at the K. U. Medical Center in Kansas City, Kansas. The program will include operative clinics with color television, cine clinics, ward walks, basic sciences in surgery, and surgical treatment of injury and cancer.

A fee of \$60.00 will be charged. Program announcements and registration cards can be obtained from the Department of Postgraduate Medical Education, University of Kansas Medical Center, Kansas City 12, Kansas.

THINGS TO COME

American Academy of General Practice, Washington, D. C., March 19-23, 1956.

Arkansas State Medical Assistants Society, Little Rock, April 14-15, 1956.

Arkansas Medical Society, Little Rock, April 23-25, 1956.

American Medical Association (Interim Session), Boston, November 29-December 2, 1955.

SEROUS OTITIS MEDIA*

CHARLES J. WATKINS, Little Rock

Those present who are expecting to hear a discussion of complications of suppurative otitis media will now be disappointed. Although these few minutes are billed on the program as "Serious Otitis Media," the real topic is serous otitis media or whatever synonym you gentlemen are in the habit of using. If a couple of us who are late arrivals had known that an excellent discourse on this subject had been delivered by Drs. Brizolara and Mahoney in 1950, we might have changed the title to "Serious Otitis Media."

All papers on serous otitis media contain about the same information. We hope today to present a few of the facts concerning serous otitis media and then add a thought or two.

Classification

I. Acute Without Effusion — This is the "blocked ear," and there may be no change in the drum.

- (a) Barotrauma—Drum may have dilated vessels at periphery and along manubrium. Drum may also be retracted.
- (b) Upper respiratory infection.
- (c) Allergy with edema around orifice of Eustachian tube.

II. Acute with Effusion—This may have rapid onset if differential in pressure is great, capillaries dilate, and later transudate appears. (Low protein; no formed elements) There is a shortened malleus, Shrapnel's membrane is pulled in. The short process of the malleus is prominent. The anterior and posterior folds of the drum are pulled tight. There may be petechia, hemorrhage, or effusion from yellowish to tobacco brown.

- (a) U. R. I.
- (b) Myringitis bullosa

III. Chronic with Effusion.

- (a) Obesity
- (b) Hypothyroidism

Serous otitis media, like most ear diseases was described by Politzer well over 80 years ago. After an early initial period of interest, study of the problem lapsed until the onset of the second world war at which time the problem of aero-otitis media stimulated investigation of the problem of fluid in the middle ear.

Anatomy

The most important anatomical facts relating to serous otitis media concern the nasopharynx and the Eustachian tube. As you well remember the Eustachian tube is higher at its tympanic orifice than it is at its pharyngeal opening. Moreover, the tympanic orifice opens 4 mm. above the floor of the tympanic cavity. From this orifice the course of the Eustachian tube is inferiorly and medially to reach the nasopharynx anterior to the torus tubarius. This point is located 1 cm. behind the septum, between 0.1 and 1.5 cm. behind the posterior tip of the inferior turbinate, and about 1.5 cm. anterior to the posterior nasopharyngeal wall. There may be varying amounts of lymphoid tissue in and about the pharyngeal orifice of the Eustachian tube.

Lateral and anterior to the pharyngeal orifice is the so-called shepherd's crook, while medial and posterior to the orifice lies the torus tubarius. From the lateral lamina to the inferior tip of the medial lamina stretches the salpingo-pharyngeal fascia and theoretically this closes off tube. The cushion of the levator veli palatini seems to push between lamina.

Physiology

Normally the Eustachian tube attempts to maintain a stable pressure in the middle ear by acting as a flutter valve. Even a slight increase in pressure in the middle ear (25 mm. Hg) can open the Eustachian tube; but from the pharynx increased pressure cannot reach the middle ear unless patient swallows. With a difference of 90 mm., of mercury even 270 will not open the tube unless the person swallows. Normally as little as 0.5 to 4 mm. of Hg pressure will open the tube with the patient swallowing.

Should the Eustachian tube be occluded the negative pressure in the middle ear will develop from absorption of oxygen, but this will not exceed 50 mms. of mercury.

All this pertains to the essentially normal Eustachian tube and does not apply to a tube that is not functioning normally.

Etiology

- (a) Lymphoid Tissue and Adenoids—Inflammation in sub epithelial tissue produces edema and infiltration and may even cause a slough of the cilia or epithelium of the Eustachian tube.

*Read before the EENT Section, Arkansas Medical Society, Hot Springs, May 31, 1955.

- (b) Tumors—If fluid is persistent. On first examination tumor may not be seen.
- (c) Nasal infection and deformity.
- (d) Nasal allergy.
- (e) Air travel.
- (f) Attenuated Otitis Media.
- (g) Mal occlusion.
- (h) Viral and bacterial infections of middle ear.

Symptoms

Loss of hearing

Tinnitus

Autophony

Fullness, numbness, or fluid sensation

Slight vertigo

SIGNS—As mentioned in classification.

So much then for what each article on serous otitis media has contained. I wish to call your attention now to the similarity between those conditions predisposing to serous otitis media and suppurative otitis media. Classically, suppurative otitis media produces an early negative pressure in the middle ear, followed by fluid, and then pus. Each of us sees patients almost daily following suppurative otitis media who have fluid in the middle ear. I wish to raise the question here, does the suppurative otitis media produce the serous otitis media, or is suppurative otitis media merely a serous otitis media which happens to become infected? Some will object to this idea,

because rarely do we see a serous otitis media become infected. However, in following serous otitis media patients over a period of time infection will occur. To carry further along, let us think about those chronic draining ears that all the antibiotics fail to dry up. Could it be that we are blinding ourselves to the true underlying pathology, namely, that of serous otitis media? There are references a plenty to the effect of allergy and adenoids upon chronic diseases of the middle ear; but always there is a direct jump from the nasal or the nasopharyngeal pathology to the chronic suppurative otitis media, without any thought that perhaps the purulent otologic infection merely triggers off a condition which existed for an indefinite period. You see these cases of chronic otitis media and I see them. The discharge is not always purulent. It may vary from a thin serous discharge to thick mucoid discharge which continues despite any and all antibiotics, regardless of the amount used. I wish to recommend that measures for the control of serous otitis media be kept in mind when dealing with chronic discharging ears.

Summary

This has been a short resume of anatomy, physiology, and etiology relating to serous otitis media, with the added thought that what we now call serous otitis media may be actually the underlying pathological process in chronic as well as acute suppurative otitis media.

HOW SAFE IS BIRTH IN ARKANSAS?*

FRANCES C. ROTHERT, Little Rock

Last year, 1954, for every 10,000 babies born alive, 8 mothers' deaths were attributed to complications of pregnancy or childbirth, 170 babies were born dead, another 169 died within their first month of life, and about 1 died with the mother, undelivered. This was the risk. (Table 1) As for the numbers of deaths, there were 35 listed as due to maternity, plus at least 9 who were pregnant or recently delivered but whose deaths were officially assigned to another cause—heart disease, kidney disease, poliomyelitis, histoplasmosis, malignancy. There were 744 stillbirths, and 738 neonatal deaths. The risk of a pregnancy ending in a maternal death was exactly three times as great for colored women as

for white. Only five years ago (1950) the risk had been twice as great as it was last year for white women, more than twice as great for non-white. In 1944, the risk was three and one-half times as great as it was in 1954, and 25 years ago, ten times and more what it was last year. (How many of you can remember the furor of 20 years ago aroused by the New York Academy of Medicine report that they considered $\frac{3}{4}$ of the maternal deaths in their study preventable?) For the child, however, there was not nearly so much improvement.

The latest year for which we can compare these figures with the United States and with other States is 1951. In that year the United States had a total maternal mortality rate of 7.5 per 10,000 live births, with 5.5 for white, and 20.1 for colored—all less than Arkansas' rates for that

*Read before the Seventy-ninth Annual Session, Arkansas Medical Society, Hot Springs, May 31, 1955.

From the Division of Maternal and Child Health, Arkansas State Board of Health.

year. Rates for individual States are given in the latest official report as average for 1950 and 1951, and for those years, only the usual four States, Mississippi, Alabama, Georgia and South Carolina, and Alaska, Puerto Rico and the Virgin Islands, had total rates higher than Arkansas. However, 12 States were worse than we in the rate for white.

Except for New Mexico and South Dakota, which had so few non-white births that the high death rates may have been due to chance, only Mississippi had a higher maternal mortality rate than we for non-white, and only very little higher at that.

In 1954 there were at least 9 deaths associated with pregnancy but not assigned to maternal causes. In the last 5 years 32 such deaths were picked up when the death certificates were being searched. There were doubtless more deaths on the certificates for which the connection with maternity was not stated. In one State in which a committee of the Medical Society annually analyzes maternal deaths for preventability, whether or not they are coded as due to maternal causes, it is reported that in one-fourth of the cases they studied, the death certificates did not show the obstetric connection. This was found half the time by cross-matching all death certificates of women aged 15 to 45 with birth certificates, and otherwise through various leads such as hospital reports. As these methods were not used in Arkansas, there were possibly twice as many of these "related" deaths as we found. Some of these you as obstetricians would doubtless say were actually due to pregnancy or childbirth. Even the 32 we did find are **not** included in the remainder of this paper.

The death certificates coded as due to pregnancy or childbirth in the last 5 years were matched to birth certificates insofar as possible. The results are given in Table II. Some twins are included so there are more births than the 236 mothers who died in the five years. For the columns headed "Miscarriage — Ectopic Pregnancy, Apparently Delivered or Apparently Undelivered" and "No Information" no birth or stillbirth certificates were found; this information was obtained from the death certificates or questionnaires that were sent in each case. In some cases, we do not know how many, the baby's birth had been reported properly but the birth certificate was sealed away when the baby was subsequently adopted and was given a new birth certificate with the name of the adoptive parents.

What were the causes of death? As the small numbers in a single State in separate years make

for considerable variability, the five years 1950-1954 inclusive were studied (Table III). Toxemias led, causing one-third of the deaths. Hemorrhage came next, followed closely by trauma and other complications, with sepsis last. The entries on the death certificates do not always make possible an accurate assignment to cause, and, as chance enters in, it is better to consider periods of longer than one year. It is of considerable interest to note that in the last two years toxemias caused 24 deaths, as compared with 46 in 1950-1951; hemorrhage caused 14 deaths in 1953-54 and 31 in 1950-51. The chief saving of life, you will observe, has been in these two conditions. As comparisons between deaths of white and non-white women are not valid without considering the number of births to each, we have given the rates per 10,000 live births for the average of last two years and for the five-year period, with rates for the United States for 1951. The differences between white and non-white, particularly in toxemia, are most striking.

Studies of maternal deaths from death and birth certificates arouse more questions than they answer. In 1938 the Maternal and Child Welfare Committee of the State Medical Society requested the State Board of Health to send a questionnaire to all physicians signing death certificates from causes connected with childbearing. This was done, and it has been continued ever since, with occasional changes in the questionnaire at the request of later committees. The plan was for the committee to study the returned case histories, which were to be presented to it without the name of the patient, or other identifying data. Committees did study many answered questionnaires, and made reports for several years. Compilations of data were presented at meetings of the committee during the early years of the war when their study of individual cases was no longer possible. With increasing pressures of the war and postwar years even the meetings of Maternal and Child Welfare Committees with Health Department Staff was discontinued. From time to time these committees would do spot checks of the death reports, and one chairman used case histories from the questionnaires as the basis of a series of articles in the State Medical Journal. A Maternal Welfare committee of a few years ago had several meetings and organized a system of personal studies of these fatalities to supplement the questionnaires but this committee's terms expired before they were able to carry out their plans. Certainly in many cases additional information is needed for a clear picture of the case. We in the Health Department have continued to send out the ques-

tionnaires, and last year, for instance, had only five unanswered. But we have made no attempt to classify the deaths according to presumed preventability. There is here a rich source of material for study by a medical society committee.

Looking through the reports you will find that many patients were first seen in convulsions. Or, as in the case of W. P., colored, delivered by a physician in a home, last year: "Second and third stages completed without difficulty. 1st twin stillborn, 2nd born alive in good condition. Following 3rd stage blood pressure began to rise and husband was advised to hospitalize patient. This was not done. Patient expired approximately 3 hours post partum. Patient did not consult a doctor or midwife during prenatal period." In only 2 of the 9 toxemia deaths in 1954 did the patient apparently have adequate prenatal care. None of the 9 were midwife cases.

A midwife was involved in four cases of maternal deaths last year—in one post partum hemorrhage case, in two deaths from sepsis, and in a presumed case of ruptured uterus—in the words of the physician who signed the death certificate: "Para 8, spontaneous delivery of viable fullterm infant, about 20 minutes later was seized by severe lower abdominal cramps, went into state of shock and expired soon thereafter—this according to midwife and attending relatives." Midwives had also been involved, insofar as we could tell with 3 cases in 1953, 5 in 1952, and in 10 cases in each of the two years 1950 and 1951.

Another woman who died in 1954 is reported to have had a normal delivery attended by an elderly Eclectic physician in a mountain town. When the placenta delivered it was seen to be firmly adherent to a completely inverted uterus. She was taken by ambulance to a hospital 50 miles away, although there are three well-equipped and -staffed nearer hospitals. She arrived in extreme shock, rallied a little after amputation of the uterus but soon died.

There was one death in 1954 following Caesarian section for premature separation of placenta. The preceding year there had been 5 deaths following Caesarian section, and one from a ruptured uterus in the 8th month of pregnancy after a previous Caesarean section.

In the years 1950-52 inclusive there had been 22 Caesarean sections among the 163 fatal cases. In 10 cases the indication had been eclampsia. Most of these Sections were done in emergencies and in small hospitals. In contrast this statement appears on the report concerning a colored patient, given by a physician who lives about 8 miles from a small hospital that had a reputation

at that time for many elective Caesareans: "Had Caesarean section 14 months previously in the State of Washington. Death due to ruptured uterus." Caesarean section, elective, would have saved this patient, but it is not feasible to do this routinely in our community. There was no physical reason for doing Caesarean section, that I could elicit.

This indignant note appears on a 1952 questionnaire on a death from post partum hemorrhage: "This patient should not have died—there was not one R.N. on duty in the hospital—a 21 gauge needle was as large as could be found in the hospital, a cannula could not be found. We gave some plasma but it was much too slow with a small needle. The laboratory technician could not be located to type donors, we already had the patient's type. 500 cc. type O whole blood was in the hospital but no one knew it. The rooms are air-conditioned, the hospital is very pretty—features which are shown the public and township politicians, but this night it was lacking in trained personnel and needed equipment and measures for handling this type complication could not be had. The baby is a cute little girl which I am going to see has everything in life she needs."

This mother had been an 18-year-old married primipara. In the 5 years there were 21 deaths of girls younger than 20, and 28 older than 40. Eighteen of the women who died were not married. Since most of you come up against the problem of a pregnant unmarried girl from time to time, the Child-Welfare Division's Medical Advisory Committee has suggested that I bring you packets of suggestions for dealing with such situations.

The title of this paper is "How Safe Is Birth In Arkansas?" The chief risk of birth is, of course, not for the mother but for the child, and unfortunately the remarkable improvement in maternal safety has not been duplicated for the child (see Table IV). As you see in this table, the stillbirth ratio seems to have improved. It is possible that formerly a number of babies, born alive but dying shortly thereafter, were reported as stillbirths—only one piece of paper to fill out that way. In one EMIC case, a number of years ago, the father insisted that the baby had lived for nearly a day, and the EMIC case report substantiated this, but the birth certificate was for a stillbirth. A question of inheritance was involved, if I remember correctly, and the certificate was eventually changed, but we got the impression that such reporting was a common practice in that particular hospital and in others.

A correction of such a condition would in itself cause an apparent improvement in the rate. On the other hand, since any product of conception is now reportable as a stillbirth, if not born with heart beat or other signs of life, we are now having more early fetal deaths reported as stillbirths, and this would mask the extent of real improvement.

It is doubtless safe to say that most neonatal deaths are obstetric casualties. In the last five years between half and two-thirds of the neonatal deaths were of premature infants, the uncertainty being due to the birth certificates on which birth weight was not reported. Even last year, when birth weight reporting had improved, the proportion of prematures among the neonatal deaths was somewhere between 70 and 50 per cent. You note how many of these deaths were among the smaller prematures. Obviously the best way to prevent these deaths is to prevent premature birth, definitely an obstetric problem, not to minimize the improvement that is still needed in the care of many of these babies after they are born.

In the prevention of needless deaths of mothers and of babies much more than obstetrics and pediatrics is involved, as you well know. The high maternal mortality rate among non-white women in particular is partly due to poverty and insufficient education and partly to lack of proper facilities for their care. Midwives still, of necessity, deliver many of them, and, as was pointed out, midwives were involved in 32, at least, of their deaths. It is not possible, as some might think, to abolish midwives by edict. We are, however, trying to keep them under control, to keep them from practicing without an annual permit, and to keep raising the requirements for these permits. These permits are now required by State Board

of Health Regulation, which has the force of law. Just this month a refractory midwife was fined and threatened with jail unless she stopped practice. This was quite a victory, as she had the backing of prominent "white folks." The last table in the set you have shows how much progress has been made in the struggle to have fewer and better midwives. The requirement that a midwife may deliver no patient who does not have a "blue card" certifying approval for midwife delivery signed by a physician (a requirement that we cannot enforce completely as yet), and the prenatal clinics—our own, and hospital clinics like that described by Dr. Harrell, are doing much to keep primiparae and women with evidence of abnormality, out of the practice of midwives. Your help is urgently needed in this, as in all the other aspects of making birth safer for mothers and babies in Arkansas.

Summary

Tables are presented showing that the risk of childbirth has been cut in half in the last five years, and is now less than one-tenth of what it was 25 years ago. This is true for both white and colored women. However, in the last year for which comparison was possible (1951) Arkansas had been surpassed in this progress by many other states. The fact that the risk is three times as great for non-white as for white women points up the continuing problem of providing facilities for adequate maternal care for Negro women. A brief statement was made concerning the State Board of Health's Midwife Control program.

Figures on Stillbirths and on Neonatal deaths according to birth weight were presented.

The great value of a Committee of the State Medical Society to make a continuous study of Maternal and Perinatal Mortality was pointed out.

TABLE I
SUMMARY—MATERNAL DEATHS—ARKANSAS—1930 - 1954

NUMBER OF DEATHS DUE TO PREGNANCY OR CHILDBIRTH				RATES PER 10,000 LIVE BIRTHS, DEATHS DUE TO PREGNANCY OR CHILDBIRTH			
Year	Total	White	Non-White	Year	Total	White	Non-White
1954.....	35	15	20	1954.....	8	5	15
1953.....	38	18	20	1953.....	9	6	17
1952.....	40	17	23	1952.....	9	6	18
1951.....	52	21	31	1951.....	12	7	26
1950.....	71	28	43	1950.....	17	10	34
1944.....	111	54	57	1944.....	28	17	58
1940.....	173	97	76	1940.....	45	33	82
1930.....	378	250	128	1930.....	90	78	142

Quiz

for

doctors

A

you probably know every answer!)

Q. Which is today's most widely prescribed broad-spectrum antibiotic?

A. ACHROMYCIN — it's first by many thousands of prescriptions.

Q. What are some of the advantages of ACHROMYCIN?

A. Wide spectrum of effectiveness.
Rapid diffusion and penetration.
Negligible side effects.

Q. Exactly how broad is the spectrum of ACHROMYCIN?

A. It has proved effective against a wide variety of infections, caused by Gram-positive and Gram-negative bacteria, rickettsia, and certain viruses and protozoa.

Q. In what way are ACHROMYCIN Capsules advantageous?

A. For rapid and complete absorption they are dry-filled, sealed capsules (a Lederle exclusive!) No oils, no paste...tamperproof.

Q. Who makes ACHROMYCIN?

A. It is produced — every gram — under rigid quality control in Lederle's own laboratories and is available only under the Lederle label.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl Lederle



LEDERLE LABORATORIES DIVISION AMERICAN *Cyanamid* COMPANY PEARL RIVER, NEW YORK

*REG. U.S. PAT. OFF.

COMPARISON WITH NATIONAL FIGURES:

	NUMBER OF DEATHS			RATES PER 10,000 LIVE BIRTHS		
	Total	White	Non-White	Total	White	Non-White
5-year average Ark. 1950-54.....	236	99	137	10.6	6.2	21.0
2-year average Ark. 1953-54.....	73	33	40	8.4	5.4	15.1
United States 1951	2,812	1,778	1,034	7.5	5.5	20.1

TABLE II
RESULTS OF PREGNANCY IN MATERNAL DEATHS—ARKANSAS—1950 - 54

	Live Births			Neonatal Deaths		
	T	W	NW	T	W	NW
1954.....	15	10	5	—	—	—
1953.....	12	7	5	1	1	—
1952.....	19	8	11	1	—	1
1951.....	19	10	9	6	3	3
1950.....	25	13	12	3	2	1
	90	48	42	11	6	5

	Still Births			Miscarriage- Ectopic Preg.			Apparently						No Information		
	T	W	NW	T	W	NW	Delivered			Undelivered			T	W	NW
1954.....	7	3	4	6	2	4	4	—	4	4	—	4	—	—	—
1953.....	8	4	4	5	2	3	3	1	2	9	4	5	1	—	1
1952.....	12	7	5	3	—	3	5	1	4	3	1	2	1	1	—
1951.....	6	2	4	6	3	3	9	3	6	8	3	5	5	—	5
1950.....	9	4	5	11	4	7	14	4	10	13	3	10	—	—	—
	42	20	22	31	11	20	35	9	26	37	11	26	7	1	6

TABLE III
NUMBER OF MATERNAL DEATHS BY CAUSE—ARKANSAS—1950 - 54

	Sepsis			Toxemia			Hemorrhage			Other		
	T	W	NW	T	W	NW	T	W	NW	T	W	NW
1954	9	4	5	9	1	8	7	4	3	10	6	4
1953	7	5	2	15	5	10	7	2	5	9	6	3
1952	9	5	4	9	3	6	13	7	6	9	2	7
1951	5	1	4	19	10	9	15	3	12	13	7	6
1950	15	3	12	27	7	20	16	10	6	13	8	5
	45	18	27	79	26	53	58	26	32	54	29	25

RATES BY CAUSE PER 10,000 LIVE BIRTHS

	Sepsis			Toxemia			Hemorrhage			Other		
	T	W	NW	T	W	NW	T	W	NW	T	W	NW
5 years, 1950-54	2.0	1.2	4.1	3.5	1.6	8.1	2.6	1.6	4.9	2.4	1.8	3.8
2 years, 1953-54	1.8	1.5	2.7	2.8	1.0	6.8	1.6	1.0	3.0	2.2	1.9	2.6
U. S., 1951	1.4	1.1	3.5	2.6	1.8	7.2	1.3	1.0	3.4	2.2	1.6	6.0

TABLE IV

	NEONATAL DEATHS			STILLBIRTHS
	Total	Apparently premature by birth weight or other information on birth or death certificates	Other	
1954	738	466	272	744
1953	786	521	280	800
1952	681	403	338	800
1951	772	451	321	847
1950	736	399	337	842

NUMBER OF LIVE BIRTHS AND NEONATAL DEATHS BY BIRTH WEIGHT
ARKANSAS--1950 - 54

	1,000 gm. or less	1,001 to 1,500	1,501 to 2,000	2,001 to 2,500	2,501 to 5,000	5,001 and over	Not Reported	Total
1954—Births	158	256	510	2,050	38,331	372	2,070	43,747
Deaths	102	107	69	94	212	12	142	738
1953—Births	118	270	554	2,032	38,026	355	2,173	43,528
Deaths	106	96	109	98	194	11	172	786
1952—Births	134	218	512	1,892	38,778	373	2,649	44,556
Deaths	81	93	69	68	193	5	172	681
1951—Births	95	236	479	1,900	38,817	455	3,721	45,703
Deaths	65	119	74	88	228	1	197	772
1950—Births	106	229	522	1,777	38,171	538	4,356	45,699
Deaths	74	75	85	66	174	7	255	736
TOTAL—Births	611	1,209	2,577	9,651	192,123	2,093	14,969	223,233
Deaths	428	490	406	414	1,001	36	938	3,713

BIRTHS REPORTED BY MIDWIVES — ARKANSAS, 1945 - 1954

Year	BIRTHS REPORTED BY MIDWIVES				NUMBER OF MIDWIVES REPORTING BIRTHS		
	% of Total Live Births	Total Number	With Permit	Without Permit	Total	With Permit	Without Permit
1945	19.5	7,751	5,305	2,446	1,403	629	774
1946	17.3	7,861	4,866	2,995	1,311	536	775
1947	15.7	7,701	5,400	2,301	1,143	580	563
1948	15.8	7,631	5,026	2,605	1,050	482	568
1949	15.1	7,606	4,911	2,677	1,024	457	567
1950	16.4	7,475	5,674	1,801	960	519	441
1951	15.7	7,158	5,050	2,108	841	438	403
1952	14.2	6,349	4,461	1,888	719	373	346
1953	13.6	5,912	4,644	1,268	616	374	242
1954	13.1	5,734	5,021	713	531	398	133

Source: Division of Maternal and Child Health, Arkansas State Board of Health.

— ★ Editorial ★ —

MR. SAM

Physicians, as well as politicians, should be looking over the presidential prospects for next year. They have a lot to lose, and they stand a good chance to lose it, too, unless some foresight is used.

Democrats are proverbially closer to the John Doakes' than are the Republicans, and physicians are well acquainted with the Doakes' families. By this token, physicians can influence, through personal contacts, probably more Democratic politicians than any other.

With this in mind, and with that other factor, Mr. Eisenhower's forced retirement, we are looking in the ranks of those in the Democratic group who stand at the head of the Party, not at its left wing (why not call them Redwings), nor at its gross conservatives, but at the head.

Our eyes fall on Sam Rayburn, best known in Washington as "Mr. Sam." We watched with some admiration his skill in out-maneuvering the left-sided insurgents, composed of "Soapy" Williams, Junior Roosevelt, Hubert Humphreys, Paul Douglas, and others, during the 1952 Democratic convention. He managed them skillfully, and victoriously. He diagnosed, and relieved the Party of their political chicanery. Our hats are off to him.

We are sure that the Journal alone can't elect "Mr. Sam" Rayburn. We are sure, also, that only lip service is given us both by Stevenson, and Eisenhower. We have no hope of getting off the Socialistic hook with either of them, and of all the possibilities in sight, who are powerful enough to make the nomination, "Mr. Sam" is our best bet.

Arkansas

TRAVELING

And Clipping Bits Here and There

We never could understand why it should be regarded as bad for people to be able to buy things cheap. It wasn't always that way, for we've had a law for a long time to prevent business competitors from getting together to boost prices up. That's a conspiracy, and that's bad. But in recent years it has become standard procedure to take everybody's money to buy up crops, simply to make everybody pay more for their gro-

ceries. By some perversion of logic, that's regarded as good.

It takes a smart man like a Congressman to figure these things. They are certainly too complicated for us.

The Pioneer, Little Rock

SOMEONE MUST PAY

In a whooping anticipation of elections ahead, the House passed sweeping revisions in the Social Security law by a vote of 372-31. The bill now goes to the Senate where, we earnestly hope, an effort will be made to find out what the taxpayers are getting into.

As with all "welfare" legislation, it is not a pleasant task to quarrel with kindly, humane proposals. It is certainly true, as the House noted, that wives are quite often a few years younger than husbands. Hence it seems reasonable to lower from 65 to 62 the age at which women qualify for old-age annuities.

The House legislation comes on the heels of administration-sponsored improvements last year, extending benefits and bringing coverage to some 10 million additional persons.

Barron's Weekly points out that in 1950, the Social Security system was paying an average of \$21 monthly to some 2.9 million persons. By June, 1954, payments were being made to 6.5 million individuals, at an average monthly rate of more than \$50.

Thus what started out as a modest program for a minimum pension of bare-sustenance proportions is mushrooming into a system promising a comfortable living for the retired, care for the disabled and dependent, and with increasing inequalities between contributions and benefits.

As we said, the advocate of caution in this progress has an ungrateful role, something like parading around the feast with a stomach pump. For who can gracefully oppose benefits for women at 62? Or 60? Or even 50? Who can argue that payments to disabled children or their widowed mothers should stop at age 18?

The fact remains, however, that these things cost money. The Social Security system is still young. It has a surplus of \$22 billion in its accounts—although the money is spent and what it has are government bonds. But the fund is piling up obligations faster than it is reserves, and sharply higher taxes for the system are already in the works.

One has only to look at the rates which private insurance companies charge for similar insurance, or deferred annuities, to realize what a tremen-

dous "bargain" the Social Security system seems to be offering. To what extent this something-for-nothing offer is a fraud upon future taxpayers is a question that sorely needs an answer.

The House did not even hold hearings upon its bill to add \$2 billion a year to Social Security costs. The Senate indicates that it will not be similarly stampeded. It should not be.

The hard truth is that the government cannot pay money to one person without having previously taken it from him or some other person. The great popular appeal of Social Security, of course, rests upon the belief that somebody else is going to get the heavy end of the check.

This expectation could be illusory for so many millions of taxpayers that a sober estimate of how many billions the government is promising, and how it will be paid for, is imperative before we go farther.

It would be unthinkable for some future Congress to renege on a contract sealed by the payment of taxes. But we also have no moral right to obligate future taxpayers to a burden that could become so great as to lower their own standard of living, while they pay for the generous but ill-advised impulses of their predecessors.

Chicago Daily News

LETHARGY

Physicians should be especially interested in social security because a full-scale social security program includes federal compulsory health insurance. That is a fact and not a conjecture as anyone will admit who is acquainted with the ILO program.

Each new Congress attempts to extend the benefits and increase the liabilities of the Social Security program in America. Busy practicing physicians have a difficult time keeping pace with the complex Washington scene and the activities of the social planners who with misguided beneficence are attempting to lead the Government into the practice of medicine. We as individual physicians tend to leave action on medical measures on our confreres who are willing to serve on the Committee on National Legislation and to our remote representatives in the Washington office of the American Medical Association. We continue our daily practices only slightly aware of the legislative struggle about us. We feel that our elected medical representatives will nicely handle our political representatives and how wrong we are in such thinking.

Our medical representatives cannot alone stem the increasing political encroachment on the practice of medicine. The passage of the discriminatory doctor's draft in spite of the opposition of

the AMA proves that point. Look at the House vote on Amendments to the Social Security Act and you will note that every Arkansas Congressman voted for it. In fact Congressman Mills of our State is given credit for drafting it.

It may be that Congressmen are beginning to feel that the AMA is not echoing the opinions of the busy medical practitioner. SO the personal voice of the individual physician must be heard by his Congressman and Senator. PLEASE TAKE TIME TO STUDY THESE MATTERS AND ACT BY CONTACTING YOUR CONGRESSMAN AND SENATORS ON A PERSONAL BASIS.

R. B. Robins

Arkansas is NOT 300 billion dollars in debt. Arkansas should finance its own schools instead of asking Washington to run up our taxes again. That includes the Medical School and certainly means our local grade and high schools. We look with alarm on the Governors' Conference of early October which **took for granted** that Federal "aid" was the answer. "Oh ye of little faith"—and of lesser vision!

BOSTON CLINICAL SESSION EXPECTED TO BE LARGEST EVER

This year's American Medical Association clinical meeting in Boston November 29 through December 2 is expected to be attended by some 4,000 persons, a large increase over last year's meeting. About 200 scientific papers and exhibits have been scheduled for presentation.

Meetings will be held in Mechanics Hall and at the Statler Hotel where the House of Delegates, the AMA's policy-making body, will hold sessions. Papers will be given in three lecture halls, offering the physician a wide variety of choice in subjects.

Among the 100-plus scientific exhibits scheduled will be displays on fractures and deliveries. The obstetrical section will include manikin demonstrations of deliveries.

Closed circuit television programs, originating in New England Deaconess hospital, will bring live operations in color to the lecture hall.

More than 50 motion pictures will be shown during the meeting, in the Paul Revere Annex of Mechanics Hall.

The technical exhibit will have more than 150 displays by medical equipment and pharmaceutical manufacturers, food processors, medical book publishers and other commercial organizations.

The General Practitioner of the Year will be named during the meeting. Last recipient of the award, chosen in Miami, was Dr. Karl Pace of Greenville, S. C.

An entertainment sidelight of the meeting will be a special concert for registrants by the Boston Symphony on Thursday, December 1. Tickets will be given at the registration desk in Mechanics Hall, courtesy of Winthrop Stearns, Inc., New York pharmaceutical house.

ANNOUNCEMENTS

"GOING OUR WAY"

A new color motion picture, "Going Our Way?", with a Hollywood cast headed by Marshall Thompson, will be released October 1 for showings before medical, pharmaceutical and allied professional groups. Showing time is 30 minutes. Bookings can be arranged free of charge by contacting John A. MacCartney, trade relations manager, Parke, Davis & Company, Joseph Campau at River, Detroit 32, Michigan.

NOTICE

Physicians interested in presenting a scientific exhibit at the Annual Meeting of the Arkansas State Medical Society April 23-25 should write to:

Lawrence M. Zell
937 Donaghey Building
Little Rock

FOLLOWING THE INTERIM MEETING

It's only a hop, skip and a jump from the occupational fatigue of the A.M.A. Clinical Session and the colonial landmarks of Boston to the tempting tropical atmosphere of Nassau.

An Official Tour to Nassau for members of the American Medical Association has been arranged for December 2-10, immediately following the A.M.A. Clinical Session in Boston.

By invitation from the Bahamas Medical Association a special medical meeting will be held at the Jungle Club in Nassau on Wednesday, December 7 for which a certificate of attendance will be issued.

Official tour folders, containing full information, may be secured by writing to A.M.A. Nassau Tour Headquarters at 35 East Monroe Street, Chicago 3.

GIVE "TODAY'S HEALTH" FOR XMAS

Add a few gift subscriptions to "Today's Health" magazine to your Christmas shopping list, and you'll surely spread health and good cheer during the holidays. During the next few

months local "Today's Health" chairmen of the Woman's Auxiliary will be contacting all physicians, dentists and Auxiliary members in their areas in efforts to top their goal of \$12,000 worth of subscriptions in the "Operation Christmas" campaign.

FILM CATALOG AVAILABLE

Medical societies and individual physicians seeking information on current films available either for professional or lay groups should write to the AMA's Committee on Medical Motion Pictures for a copy of its latest catalog of medical and health films.

AT K.U.

The Department of Medicine at the University of Kansas School of Medicine has announced new postgraduate opportunities of in-residence training in the fields of Cardiovascular Disease and Pulmonary Disease. These programs will offer the graduate physician opportunities to obtain supervised experience and training in many of the newer techniques now in use.

The starting dates for the training in Cardiovascular Disease are: November 1, 1955, March 1, April 1 and May 1, 1956. Training will begin in Pulmonary Disease on: November 1, 1955, January 2, April 1 and May 1, 1956.

The programs are of one month duration and are limited to two enrollments in each field. Applications for this postgraduate work should be directed to the Department of Postgraduate Medical Education, K. U. School of Medicine, Kansas City, Kansas.

AT CINCINNATI

The University of Cincinnati's Institute of Industrial Health is offering graduate fellowships in Industrial Medicine. The Institute, which is in the College of Medicine, provides professional training for graduates of approved medical schools who have completed at least one year of internship. The course is three years in length.

Stipends vary from \$3,000 to \$4,000. In the final or residency year a fellow is compensated by the organization in which he is completing his training.

Requests for additional information should be addressed to Secretary, Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

REPRODUCED FOR ARKANSAS PHYSICIANS BY THE ARKANSAS TUBERCULOSIS ASSOCIATION

"A CHRISTMAS SEAL SERVICE"

TUBERCULOSIS—1955. IS HOSPITAL CARE NECESSARY?

By RALPH E. DWORK, M.D., M.P.H.

The Ohio State Medical Journal, May, 1955

The rapidly changing pattern of treatment of tuberculosis, especially since the announcement of isoniazid early in 1952, has made it increasingly important to "keep up" in this field. Questions have arisen regarding the need for hospital care, the duration of such care, and the intelligent handling of antimicrobial drug therapy. For these reasons it has seemed desirable for the Ohio Department of Health to present the best informed opinion available at this time.

(1) How have drugs influenced the duration of hospital care? Drug therapy has shortened both the average duration of hospital care and duration of bed rest for patients with early active disease. It has lengthened the period of hospital care for a significantly large group of patients, who would otherwise die early, but now are kept alive as chronic cases for a long time, with drug therapy.

(2) Is hospital care necessary for all active cases or will home treatment suffice for many such patients? If there are insufficient beds available, home treatment using anti-TB drugs is obviously the next best procedure. Rather dramatic early improvement is often seen in active TB treated at home with anti-TB drugs, but some such cases suffer "spread" of disease and may lose their chances for recovery.

Recently, James J. Waring, M.D., a former president of the National Tuberculosis Association, acknowledging the disadvantages of TB hospital care, such as expense, separation from family, and restrictions of hospital living, pointed out the serious deficiencies of home care in tuberculosis: Members of the family and the public are frequently exposed unnecessarily to tubercle bacilli. The patient at home seldom obtains an understanding of his disease and the attitude toward its long-term treatment which will lead him to protect his health long after active treatment has been stopped. This "education" which comes

from the staff and other patients in the TB hospital is usually not accomplished when the patient is treated at home. Systematic rest at home is difficult to attain without supervision. In the hospital, rest is a prime consideration. The early weeks of drug therapy are often complicated by symptoms requiring changes in regimen, insistence on regular administration, and moral support by the staff. At home the drugs prescribed may be omitted or taken irregularly with the result that early drug resistance develops. Toxicities of drugs in use and complications may go unrecognized for long periods when the patient is at home. In the hospital such incidents are handled safely and promptly. The increased importance of surgery in tuberculosis makes it essential that the strategic moment for intervention not be missed. Recent experience indicates that many patients treated at home are not being considered for surgery at any time. The technical facilities of laboratory and X-ray often provide crucial information determining the course of therapy. Such aids are often inadequately provided in home treatment but the hospital patient usually has access to the necessary services. Altogether, it is seen that while home treatment of tuberculosis may, at times, be successful, there are many hazards associated with it.

After viewing the problem of rest and exercise, the Committee on Therapy of the American Trudeau Society recently said, "The Committee on Therapy points out again that, from the facts now available, there is no evidence to support a reduction in the amount of rest therapy from that of past practices except as it may be justified by an earlier attainment of an inactive status of the disease . . . The patient should be hospitalized, if at all possible, throughout the infectious stage of his disease. In addition to the benefits of hospitalization to the patient, this is sound public health practice to prevent the spread of tuberculosis . . . The total period of disability, though

greatly shortened, on the average, with antimicrobial therapy, must still be estimated at a minimum of one year, even in mild cases which respond favorably to treatment."

When there were insufficient beds for the care of tuberculosis patients, there may have been some justification for individual cases remaining at home. Now that beds are available, a special obligation falls on the health departments and practicing physicians to see that "active cases" and potentially "infectious cases" are in hospital beds.

Public health officers and practicing physicians are in a strong position in insisting that every case of active tuberculosis have a period of treatment in a tuberculosis hospital. This period will be variable in length but must continue until the patient is not a hazard to his associates and until all therapeutic factors have been utilized to the patient's maximum benefit. The Ohio Department of Health recommends that all health departments and practicing physicians take a firm stand to the end that the process of tuberculosis control be accelerated to its maximum.

PREVALENCE OF TUBERCULOSIS IN LARGE CITIES*

Although there is considerable optimism regarding tuberculosis as a result of the introduction of new chemotherapeutic agents and the rapidly falling death rate, physicians close to the tuberculosis problem believe this may not be entirely warranted. There is good reason to believe that the prevalence (total number of cases of tuberculosis in the community) may actually be increasing.

One reason for the increasing prevalence of tuberculosis lies in the survival rate of numerous patients currently treated, as compared with the prechemotherapeutic era. Prior to 1946, most large tuberculosis institutions reported an annual death rate of about 30 per cent of the number of yearly admissions. The current rate in most of these institutions is under 10 per cent. As survivors return to community life from the sanatorium, some inevitably undergo a relapse, and infect other persons, possibly with tubercle bacilli already resistant to antituberculosis drugs.

A second factor that contributes to an increase in the number of tuberculosis patients living at home can be attributed to the outpatient programs. This type of program varies considerably from city to city. In New York, treatment is administered to patients who have left sanatoriums against medical advice, as well as to those who

refuse to enter sanatoriums. Many of these patients have negative sputum. On the debit side, however, it is probable that many of these patients will relapse and many will refuse to undergo effective surgery. In the Chicago program, recalcitrant patients are untreated; only postsanatorium patients selected for early discharge are given outpatient treatment. The relapse rate for these selected cases has been reported as being very low.

A third factor that contributes to an increase in the number of tuberculosis patients at home is due to enthusiastic publicity on the efficacy of antituberculosis drugs. Many newly discovered tuberculosis patients are encouraged by this publicity to refuse sanatorium care and many sanatorium patients leave before treatment has been completed. Survivors who formerly would have died, patients with surgical collapse, a large number of "good chronics" who are clinically well but bacteriologically positive, and numerous recalcitrant, inadequately treated patients present a threat to effective tuberculosis control.

Effective management of increased prevalence of tuberculosis in a community requires improved supervision of patients residing at home, improved liaison between sanatoriums and outpatient clinics, and greater restriction of tuberculosis "public health menace" patients. While great strides have been made recently in tuberculosis therapy, what still remains to be accomplished should not be minimized in this most prevalent of all infectious diseases.



*Editorial, The Journal of the American Medical Association, February 5, 1955.

Obituary

CORDY NORFORD PATE, 77, a prominent physician in Hot Springs for 35 years, died of a heart attack in his office October 1. Dr. Pate established his Hot Springs practice in 1920. He was born in Coffeetown, Miss., and received his medical training at Memphis Hospital Medical College, which was later consolidated with the University of Tennessee College of Medicine. He practiced general medicine at Fort Smith from 1904 until 1912. Afterwards, he interned at Tulane University hospital, where he specialized in ear, eyes, nose and throat. Dr. Pate was a member of the American Medical Society, the Southern Medical and Garland County Medical Societies. He also was a 32nd degree Mason, a member of Hot Springs Lodge No. 62, and the Knights Templars and Shrine Club. He was presented with the "Golden T" certificate at commencement exercises of the University of Tennessee Medical College in 1953 for services to the community for 50 years. Survivors include: His wife, Mrs. Ione Pate, one daughter and three grandchildren. Funeral services were held at the Gross Chapel with the Rev. J. C. Melton, pastor of the Memorial Baptist Church, officiating. Burial was in Memorial Park Cemetery.

C. J. HIGINBOTHAM, long-time Pine Bluff physician, died September 21 at the Veterans Administration Hospital in Little Rock where he had been undergoing treatment for several weeks. Dr. Higinbotham, 76, came to Pine Bluff with his parents, Horace G. and Dr. Lillian G. Starkweather Higinbotham, in 1879. He received his early education here and later attended the Holman Medical School in Chicago. He was a member of the First Presbyterian Church, American Legion, the VFW, the Sojourners, Pine Bluff Lodge No. 69 of F. & A. M., the Lafayette Chapter No. 14 of Royal and Select Masons, the Damascus Commandery No. 8 and the Sahara Shrine Temple. He was a member of his local and county medical societies and of the Arkansas Medical Society. He served as a major in France during World War I. There were no immediate survivors. Funeral services were held at the First Presbyterian Church. Burial was at Graceland Cemetery.

PERSONAL AND NEWS ITEMS

John T. Herron, State Health Officer, Little Rock, and President L. H. McDaniel, Tyronza, were speakers at the October meeting of the Arkansas Public Health Association.

Kenneth G. Jones and Horace R. Murphy have opened an Orthopedic Clinic on West Markham in Little Rock.

James O. Porter announces the opening of his office for obstetrics and gynecology with Alex Gillespie, in Little Rock.

Hal R. Black and Curry B. Bradburn attended the Tri-State Urological Meeting at Texarkana, September 28.

W. J. Hunt and Mrs. Hunt of Magnolia, celebrated their Golden Wedding Anniversary August 28. He has practiced medicine for 54 years in Columbia County.

William Morse, Memphis urologist and a native of Blytheville, addressed the Mississippi County Medical Society on September 13 at the Memorial Hospital in Osceola. Among the members present were I. R. Johnson, Blytheville, who delivered the speaker some 30 years ago. Lew Phillips, W. O. Green, and I. L. Carlton joined the society at this time.

J. C. McMahan, formerly of Clinton, has moved to Hot Springs.

J. S. Priddy, Green Forest, is opening a new clinic-office building in November.

President L. H. McDaniel, Tyronza, and Ross E. Maynard, Pine Bluff, addressed the Arkansas State Practical Nurses Association at their Pine Bluff meeting, October 4.

Lee County citizens led by the local medicos and the Chamber of Commerce of Marianna are voting this fall on a tax for a new County Hospital.

The resignation of the County Physician in Garland County left the treatment of their indigent cases to the generosity of members of the Garland County Medical Society. Thanks to their services, the people are being taken care of in most cases from time and skill donated by these physicians, says Mrs. Dorothea Marlin, County Probation Officer.

Richard V. Ebert, Little Rock, was a featured speaker at the Oklahoma City Clinical Society meeting in October. He spoke on "The Mechanism of Dyspnea" and "Shock and Syncope."

Hempstead County Memorial Hospital was opened September 16. Governor Orval Faubus and Congressman Oren Harris were featured speakers.

Arkansas names appearing on the Calendar of Events at the Southern Medical Association meeting November 14-17, 1955, were: Willis E. Brown, James C. Atkinson, B. G. Henley, Thomas G. Johnston, Richard V. Ebert, S. William Ross, and William Scarlett, all of Little Rock; E. K. Clardy, Hot Springs, and Ben N. Saltzman, Mountain Home.

Jim McKenzie, Hope, is chief of staff of the newly opened Hempstead Memorial Hospital.

George L. Ackerman, a graduate of the University of Arkansas Medical School, has returned from a year's work in Philadelphia General Hospital and opened an office in his home town of Rison.

H. A. Rands, Dumas, is new Chief of Staff at the Desha County Hospital.

Baby Girl Norton, a Bundle from Heaven, dropped in on Joe and Mrs. Norton October 6.

J. T. Irby, Earle, was honored recently by his extensive list of friends who celebrate with him his community service for 50 years. He has throughout these years been actively associated with public affairs, his church, schools and community problems.

WOMAN'S AUXILIARY NOTES

Mrs. Mason Lawson, Little Rock, President of the Woman's Auxiliary to the American Medical Association, served as one of the judges of the 1955 Carol Lane Awards sponsored by the National Safety Council. The awards were presented at a luncheon held during the National Safety Congress held in Chicago October 17-19.

As president of the Auxiliary, she attended the Conference of State Presidents, Presidents-Elect, and national committee chairmen which was held in Chicago October 31-November 3.

On October 27, Mrs. Lawson participated on a panel discussion of "The Professional Nurse and Contemporary Science" at a meeting of the Arkansas State Nurses Association.

PROCEEDINGS OF SOCIETIES

Note: Secretaries of County and District Societies are invited to use this column to announce coming meetings as well as to report these meetings. Such meetings, announced in advance, will be more apt to draw visiting physicians from surrounding areas.

A complete list of Arkansas physicians registered at the Southwestern Surgical Conference in Kansas City last September is given:

John Dorman, Friedman Sisco, Springdale; John H. Wilson, Joseph F. Rushton, Magnolia; Morton Wilson, Fort Smith; Martin C. Hawkins, Jr., Searcy; Harry Hayes, Little Rock; James H. Growdon, Little Rock; Marlin Hoge, Fort Smith; Joseph Buchman, Little Rock; John W. Downs, Little Rock; Jean C. Gladden, Harrison; W. J. Fink, Fayetteville; Louis P. Good, Texarkana; A. B. Dickey, formerly of State Sanatorium; W. E. Jennings, Rogers; E. J. Stroud, El Dorado; W. D. Cooper, Jr., Little Rock; A. S. J. Clarke, Texarkana; Robert Stainton, Little Rock; and F. H. Krock, Fort Smith.

Ben N. Saltzman, Mountain Home, was installed as President of the Arkansas Academy of General Practice at its annual fall seminar held in Little Rock, October 6-7. Newly elected officers were W. A. Snodgrass, Jr., Little Rock, President-Elect; C. C. Long, Ozark, Vice-President; and L. A. Whittaker, Fort Smith, Secretary-Treasurer. Delegates of the Arkansas chapter to the American Academy of General Practice are James M. Kolb, Clarksville, and C. R. Ellis, Malvern. More than 100 physicians registered at the meeting.

Craighead-Poinsett Medical Society met October 5 at Jonesboro and heard Ralph Bethea, Memphis, on "Extra Uterine Pregnancy" and Alva B. Weir, Jr., Memphis, on "Handling the Refractory Cardiac Patient." More than 40 members and guests were present.

The American Otorhinologic Society for Plastic Surgery is giving a three day course with international coverage at the Morrison Hotel in Chicago, November 7-9, preceding the meeting of the American Academy of Ophthalmology and Otolaryngology.

Paul L. Mahoney, Little Rock, is a member of the Board of Directors of the Society and a member of its faculty.

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Smoothage in Correction of Colon Stasis

To initiate the normal defecation reflex, the “smoothage” and bulk of Metamucil provide the needed gentle rectal distention.

Once the habit of constipation has been established, due to any of a large number of causes, it becomes a major problem. Self-medication with irritant or chemical laxatives, or repeated enemas, usually causes a decreased, sluggish defecation reflex and may result in its complete loss.

Rectal distention is a vital factor in initiating the normal defecation reflex, and sufficient bulk is thus of obvious importance in restoring this reflex. Metamucil provides this bulk in the form of a smooth, nonirritating, soft, hydrophilic colloid which gently distends the rectum and initiates the desire to evacuate. Metamucil demands extra fluid, imparting even greater smoothage to the intestinal contents.

It is indicated in chronic constipation of various types—including distal colon stasis of the

“irritable colon” syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined muciloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. G. D. Searle & Co., Research in the Service of Medicine.

SEARLE

J. H. McCurry, Cash, long-time correspondent for the Craighead-Poinsett County Medical Society, furnishes us with the feature article of the Memphis Commercial Appeal on July 31, 1953.

The paper honors J. K. Hampson, Wilson, for his long practice of medicine and for his unusual and interesting hobby. Dr. Hampson practiced for 10 years in Fort Smith and later moved to eastern Arkansas to the house that was his boyhood home. He lives there now at 78 and has collected in many years more than 4,000 Indian relics. In addition, his hobbies have netted him several guns, knives, swords, and shields. He graduated in Medicine in Memphis in 1898 and has been an enthusiastic Arkansawian since his boyhood. He lives quietly among his friends in the neighborhood that he has called home for every day of his life.

The District Medical Society met October 6 at Camden, where Malcom E. Phelps, El Reno; John Jones, Texarkana; and Dean F. Douglas Lawrason, Little Rock, were guest speakers. Paul Sizemore, Magnolia, is President.

Pulaski County Medical Society met October 3 in the amphitheater of the School of Medicine to hear William B. Seaman, Associate Professor of Radiology at the Washington University School of Medicine, St. Louis.

BOOK REVIEWS

Clinical Biochemistry: Abraham Cantarow, M. D., Professor of Biochemistry, Jefferson Medical College, and Max Trumper, Ph.D. Edition: Fifth. Pp. 738. Illustrated. 1955. \$9.00. W. B. Saunders Company, Philadelphia.

When the first edition of this book was published twenty-five years ago, there was an unfortunately wide gap between the accumulated knowledge of the so-called "fundamental" biochemistry and physiology and that of clinical medicine. At that time the avowed purpose of the book was to aid both the student and the physician in translating biochemical knowledge for clinical practice. Though the distance to be bridged has shortened in the intervening years, due mainly to closer integration in the teaching of clinical medicine and the basic medical sciences, this stated purpose is still valid. Since the last edition (1949), research in biochemistry has been both prolific and penetrating in the investigation of the chemical aspects of life processes. To take full advantage of these recent, specialized contributions requires careful selection, condensation and organization of the pertinent observations in a useful manner. Dr. Cantarow has admirably succeeded in the difficult, but necessary undertaking.

The areas of biochemical research which have made considerable progress in recent years, and which the author has judged desirable to present in condensed form include: plasma protein metabolism and abnormalities, nucleic acid and uric acid metabolism, porphyrin metabolism, iodine metabolism, lipoproteins, fatty liver and hormones. New material has also been included in the areas of liver func-

tion, kidney function, biochemical aspects of diet, potassium metabolism, water balance and respiratory exchange. Most of the text has been completely rewritten in a lucid style and in a rational order of development.

The reviewer noted several deficiencies. Discussion of pyridoxine was not included in the chapter on vitamins, though this vitamin is now known to be required by the human infant. The utilization of pteroylglutamic acid (folic acid) and cobalamin (vitamin B₁₂) in treatment of anemias is not evident, although it has relevance to the biochemical approach to the diagnosis or management of clinical disorders. In several instances, the index has not kept pace with the growth of the text. The diagrams, printing and binding of the book are of high quality. The book is recommended for either the medical student or practicing physician who wishes to avail himself of a modern interpretation of the significance and limitations of biochemistry in modern medicine.

R. L. Wixom

Surgical Forum: Proceedings of the Forum Sessions, 40th Clinical Congress of the American College of Surgeons, Atlantic City, N. J., November 1954. Committee on Forum on Fundamental Surgical Problems: Harris B. Shumacker, Jr., M. D., F. A. C. S., Indianapolis, Chairman. Pp. 851. Illustrated. 1955. \$10.00.

This report of an extensive symposium on Fundamental Surgical Problems is from many heads of research in our various schools throughout the United States. Its content is, therefore, considerable on the theoretical considerations of surgical problems rather than on exposition of technique or a reference to the ordinarily accepted surgical procedures.

The book will be an asset and a valuable reference work for a medical school or a teaching hospital library.

S. D. Brown

Office Procedures: Paul Williamson, M. D. Pp. 412. W. B. Saunders Company, Philadelphia. Illustrated. 1955. \$12.50.

There are many times in the practice of general medicine when it becomes necessary to do a procedure, simple enough, but one that isn't done daily, and a task on which the operator is a little rusty on technique. This new text is almost a panacea for such things. It is simply and directly written; the illustrations are outline in nature and excellent. It is strictly up-to-date.

The text has a special appeal to a younger man, beginning his practice, and for the general man at any time that a quick thumb-nail review is desirable.

It has a well defined table of contents and an excellent index. Type used is large—reading is easy and the format of the book is excellent.

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...The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

DECEMBER, 1955

No. 7

MODERN RHINOPLASTY

By SAMUEL FOMON, New York; PAUL L. MAHONEY, Little Rock

PREOPERATIVE MANAGEMENT

One hour before operation, 2 capsules (0.13 gm.) nembutal are administered.

The vibrissae are clipped with blunt-end scissors, care being taken not to puncture the vestibular skin. The vestibules are then scrubbed with physoderm on cotton-tipped applicators.

The nasal fossae are anesthetized as follows: Three cotton-tipped applicators are dipped in a solution of equal parts 10 per cent cocaine and 1:1000 adrenalin, and after the excess fluid has

Trilene is administered with an inhaler for the duration of 9 or 10 respirations.

OPERATIVE MANAGEMENT

Anesthetization of External Nasal Pyramid

The left ala is elevated with a 2-pronged retractor, and the plica nasi (anatomic shelf formed by the lower margin of the upper lateral cartilage) is located. A 5 cm. 24-gauge needle is placed at the center of the upper surface of this ledge (Figure 2). Under control of the fingers the needle is advanced in the plane above the perichondrium and periosteum to the nasal root, and 0.5 cc. of solution—1.5 per cent monocain to which have been added 10 drops to the ounce 1:1000 adrenalin—is discharged (infratrochlear nerve block). The needle is withdrawn to the junction of the nasal bone and upper lateral cartilage, and another 0.5 cc. is deposited (external nasal nerve block) (Figure 2). The procedure is repeated on the opposite side.

A 4 cm. 24-gauge needle is now introduced intranasally at the outermost margin of the piriform opening and carried to a point at the imaginary

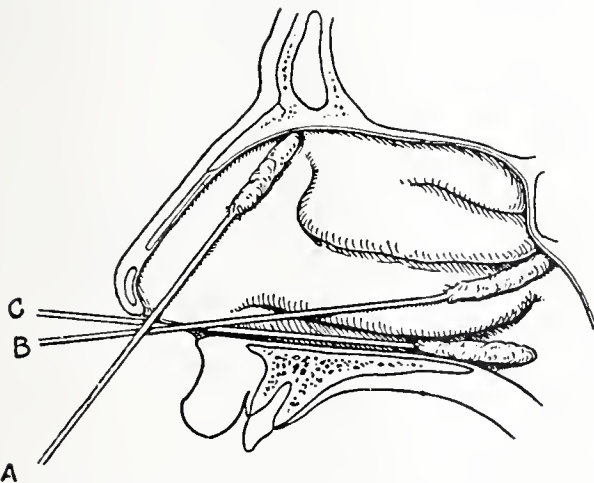


Fig. 1—Anesthetization of nasal mucosa by direct block. A, internal nasal nerve block; B, sphenopalatine block; C, nasopalatine and anterior palatine block.

been squeezed out, are inserted as follows (Figure 1): (a) One beneath dorsum along olfactory sulcus (internal nasal nerve block), (b) one at foot of middle concha (sphenopalatine ganglion block), (c) one along floor of nose (nasopalatine and anterior palatine nerve block). The procedure is repeated on the opposite side.

Two drops sterile castor oil are now instilled into each eye. The patient is transferred to the operating table, with the head slightly elevated on the pillow.

The nasal applicators are withdrawn, the face and vestibules are scrubbed with physoderm on gauze sponges for 2 minutes, and the area is draped with sterile linen.

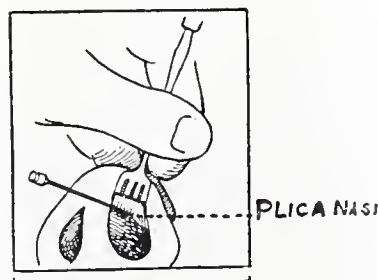
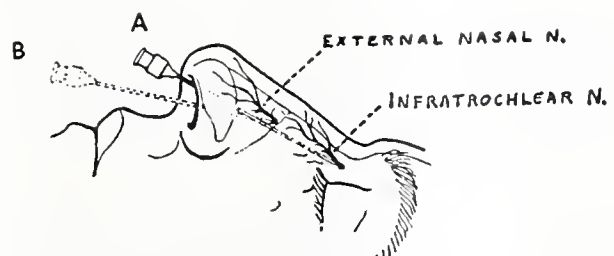


Fig. 2—Infratrochlear and external nasal block. A, 5 cm. 24-gauge needle introduced into plica nasi and advanced to nasal root, where 0.5 cc. of solution is discharged; B, needle withdrawn to caudal margin of nasal bone, and 0.5 cc. discharged.

intersection of a vertical line drawn 1 cm. lateral to the inner canthus and an oblique line from the columella to the lateral canthus (Figure 3). Here 0.5 cc. of solution is discharged as the needle is withdrawn (infraorbital nerve block). The procedure is repeated on the opposite side.

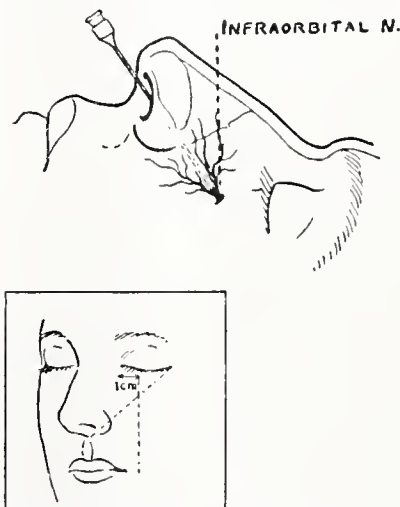


Fig. 3—Infraorbital block. 4 cm. 24-gauge needle introduced at outermost margin of piriform opening, carried to intersection shown in insert, and 0.5 cc. of solution discharged.

A 2.5 cm. 24-gauge needle is introduced at the anterior nasal spine and advanced along the floor of the nose to the incisive foramen. On withdrawal 0.5 cc. of solution is discharged (nasopalatine and anterior palatine nerve block) (Figure 4).

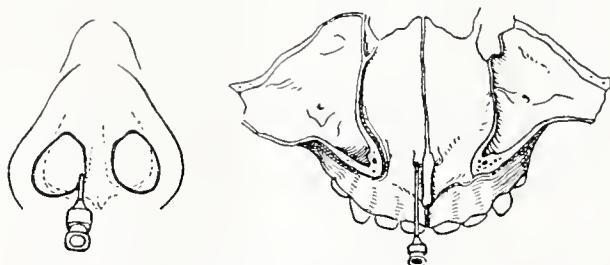


Fig. 4—Anterior palatine and nasopalatine block. 2.5 cm. 24-gauge needle introduced at anterior nasal spine, advanced along floor to incisive foramen, and 0.5 cc. of solution discharged.

The columella and alar wall are then infiltrated. The procedure is repeated on the opposite side.

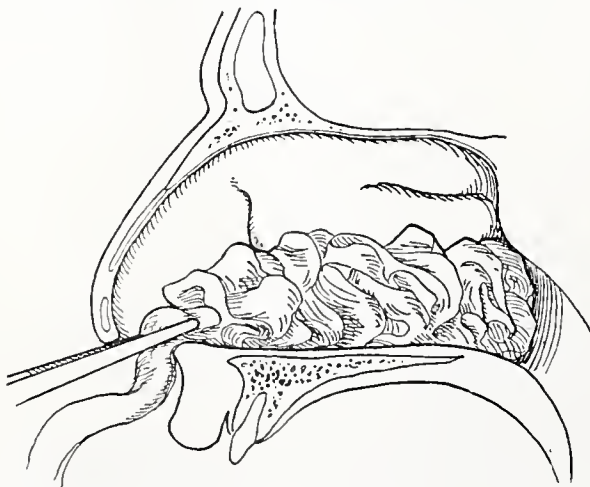


Fig. 5—Introduction of gauze strip, to prevent escape of blood into nasopharynx.

The nasal fossae are packed with long strips of half-inch gauze, the vestibules being left clear (Figure 5).

Uncovering of Nasal Framework

The left ala is elevated with a retractor, and the plica nasi is located. With a Bard Parker No. 11 knife the aponeurosis connecting the upper and lower lateral cartilages is incised, the incision starting at the center of the plica and extending ventrally to the septum and along the caudal margin, halfway to the nasal spine (Figure 6). A similar incision is made on the opposite side.



Fig. 6—Exposure of plica nasi and incision of aponeurosis connecting upper and lower lateral cartilages with Bard Parker No. 11 knife.

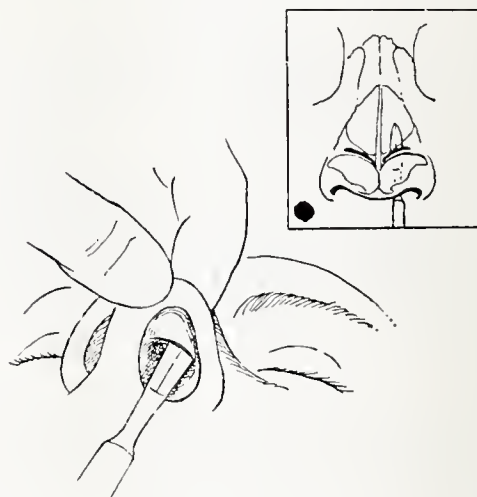


Fig. 7—Elevation of soft structures overlying upper cartilaginous vault.

A straight, pointed double-edged Joseph knife is introduced into the left incision (Figure 7) and carried to the nasofrontal articulation in the plane immediately above the perichondrium and periosteum. The knife is swept from side to side, separating the structures for a distance equal to the width of the blade, and withdrawn (Figure 8). The procedure is repeated on the right side.

A Fomon curved double-edged blunt-tipped knife is now introduced through the left incision, and the separation is continued over the dorsum in the same plane as before (Figure 9). The procedure is repeated on the opposite side.

A MacKenty elevator is inserted through the left incision, and the periosteum is incised at the predetermined site of the saw-cut (Figure 10). The procedure is repeated on the opposite side. The soft tissues overlying the ventral and lateral nasal walls are thus freed.

A button-end knife is introduced through the left incision and swept obliquely downward across the dorsum, until the tip appears through the intercartilaginous incision in the right vestibule (Figure 11).

Without any alteration in the plane of the knife (which now transfixes the nose), the incision is continued to the caudal end of the septum.

The knife is now turned at right angles and, with its blade hugging the caudal margin of the septal cartilage, the membranous septum is straddled

with a straight Mayo scissor held perpendicular to the nasal spine, the points of the scissor being made to lie on the nasal spine (Figure 12). With one snip of the scissor the separation is completed.

The left ala is retracted, and with a Bard Parker No. 15 knife a circumferential incision is made through the vestibular skin along the lower margin of the lower lateral cartilage (Figure 13).

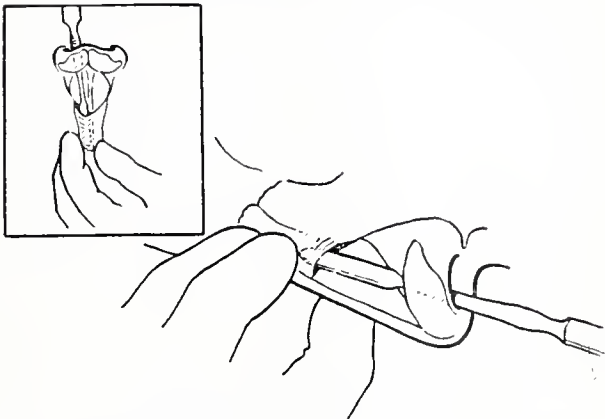


Fig. 10—Elevation of periosteum over nasal bone.

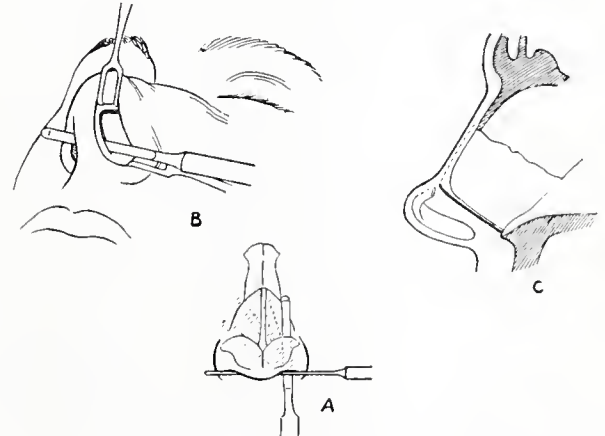


Fig. 11—Caudal exposure of nasal pyramid. A, button-end knife introduced, advanced to nasofrontal suture, and swept obliquely downward until tip appears through opposite intercartilaginous incision; B, membranous septum cut through; C, line of separation.

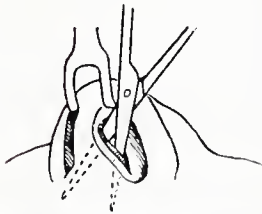


Fig. 12—Completion of caudal exposure. Membranous septum straddled by Mayo scissors, and structures divided to nasal spine.

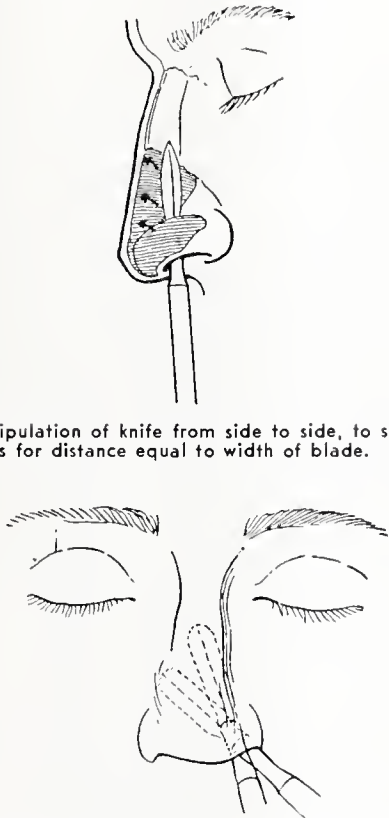


Fig. 8—Manipulation of knife from side to side, to separate structures for distance equal to width of blade.

Fig. 9—Separation of soft structures over dorsum with blunt, curved, double-edged knife.



Fig. 13—Exposure of lower lateral cartilages. A, marginal incision made along caudal border; B, overlying soft structures elevated; C, cartilage exposed; D, angle cut through on grooved director.

A blunt double-edged scissor is introduced between the lower lateral cartilage and the overlying structures and kept on the plane immediately above the perichondrium.

With the scissor carried obliquely, the overlying structures are gradually separated, until the angle of the lower lateral cartilage is entirely freed. The procedure is repeated on the opposite side, so that the separation over the entire lobule is complete.

A dural hook is now inserted beneath the angle of the left lower lateral cartilage, and the cartilage is drawn out of the nostril. Under this double-pedicated vestibular skin-cartilage flap a strabismus hook is passed and the angle cut through (Figure 13). The procedure is repeated on the right lower lateral cartilage.

Modeling of Base of Pyramid (Lower Cartilaginous Vault)

The rhinoplasty is begun with the modeling of the base, for this segment furnishes an index to the faults in the balance of the nose.

Reconstruction of Columella

Figure 14 illustrates the steps in the reconstruction of the columella.

Positioning of Columellar-Labial Junction: The columella should join the lip at a point 2 to 3 mm. below the level of the alarlabial junction (Figure 14). If the junction between columella and lip is too low, it is raised by a cautious excision of the caudodorsal portion of the septum and/or nasal spine, and the parts are slid up into the space thus created. If the junction is retracted, it is brought out at the expense of the columellar width

as follows: A raw surface is created at the base of the columella by a separation of the walls with scissors, and a mattress suture is passed and tied to bring about the desired projection (Figure 15).

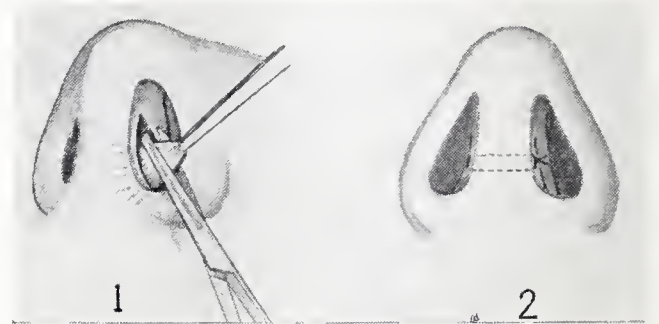


Fig. 15—Reduction of width and projection of columella. 1, excess subcutaneous tissue removed; 2, columellar walls approximated.

If there is still a lack of projection, the lip is buckled as described below (Figure 21), or a graft modeled from the hump or removed from the septum is introduced.

Reconstruction of Columellar Length (Figure 14): The columella should be 2 to 3 mm. longer than the vertical length of the lip. If the columella is too long, it is shortened by a transfer of the excess columellar tissue into the lip. If too short, it is lengthened at the expense of the lip. One needle of a double-armed suture enters the skin of the columella and is pushed through to emerge from one of the columellar walls. It is then carried through the dorsocaudal (posteroinferior) part of the septum and brought out through the naris. The other needle is carried through the original point of entry, brought out through the other columellar wall, and the ends are tied. If the columella is too long, the needle is introduced on the columellar site; if too short, on the labial site (Figure 16).

Reconstruction of Columellar Inclination (Shortening of Nose) (Figure 17): In a nose of normal

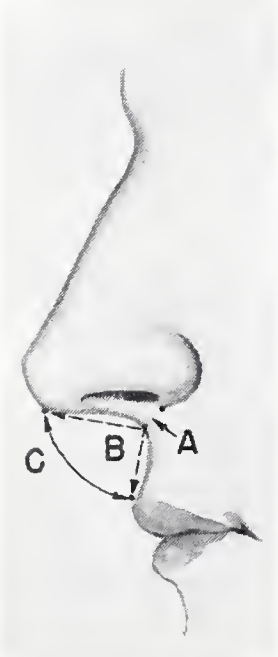


Fig. 14—Reconstruction of columella. A, columella should join lip at point 2 to 3 mm. below alarlabial junction; B, columella should be 2 to 3 mm. longer than vertical length of lip; C, columella should form angle with lip of 90 to 95 degrees in men and 100 to 110 degrees in women.

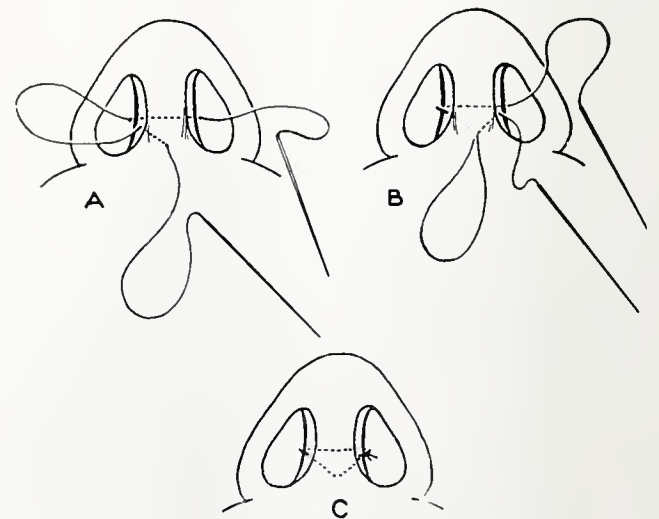


Fig. 16—Suture for lengthening or shortening columella. For details, see text.

length the slope of the nares forms an angle with the lip of 90 to 95 degrees in men and 100 to 110 degrees in women, provided the lip is normal (Figure 14). The columella is grasped between thumb and forefinger, and with an upward (cephalad) and backward (dorsad) motion the lower cartilaginous vault is telescoped over the upper until the desired relationship between lip and nares is obtained. With the aponeurosis between the upper and lower lateral cartilages cut, this position is automatically maintained by the contraction of the overlying skin.

The long nose has thus been converted into a nose of normal length with a secondary deformity consisting of a hanging columella due to the projecting septum. This is now attended to. The columella is pushed to one side of the septum and raised until it comes to lie 2 to 3 mm. below the alar margin. A scratch is made at this level

on the septum, and the part below is excised (Figure 18).

Reconstruction of Basal Triangle

Viewed from below, the base of the pyramid in a normal nose forms an equilateral triangle in which the interalar distance is equal to the length of the side walls. This relationship is determined with calipers (Figure 19). The points are placed at the junctions of the alae with the lip. The instrument is locked and one limb swung to the midline. If it falls exactly on the center of the tip, the projection is normal; if it comes to lie below the center, the tip is unduly projecting; and if above, receding.

Reconstruction of Back Wall of Triangle (Dorsal Wall; Base of Triangle) (Figure 20): If the alae project beyond the intercanthal lines, the base of the triangle is too wide and must be reduced to

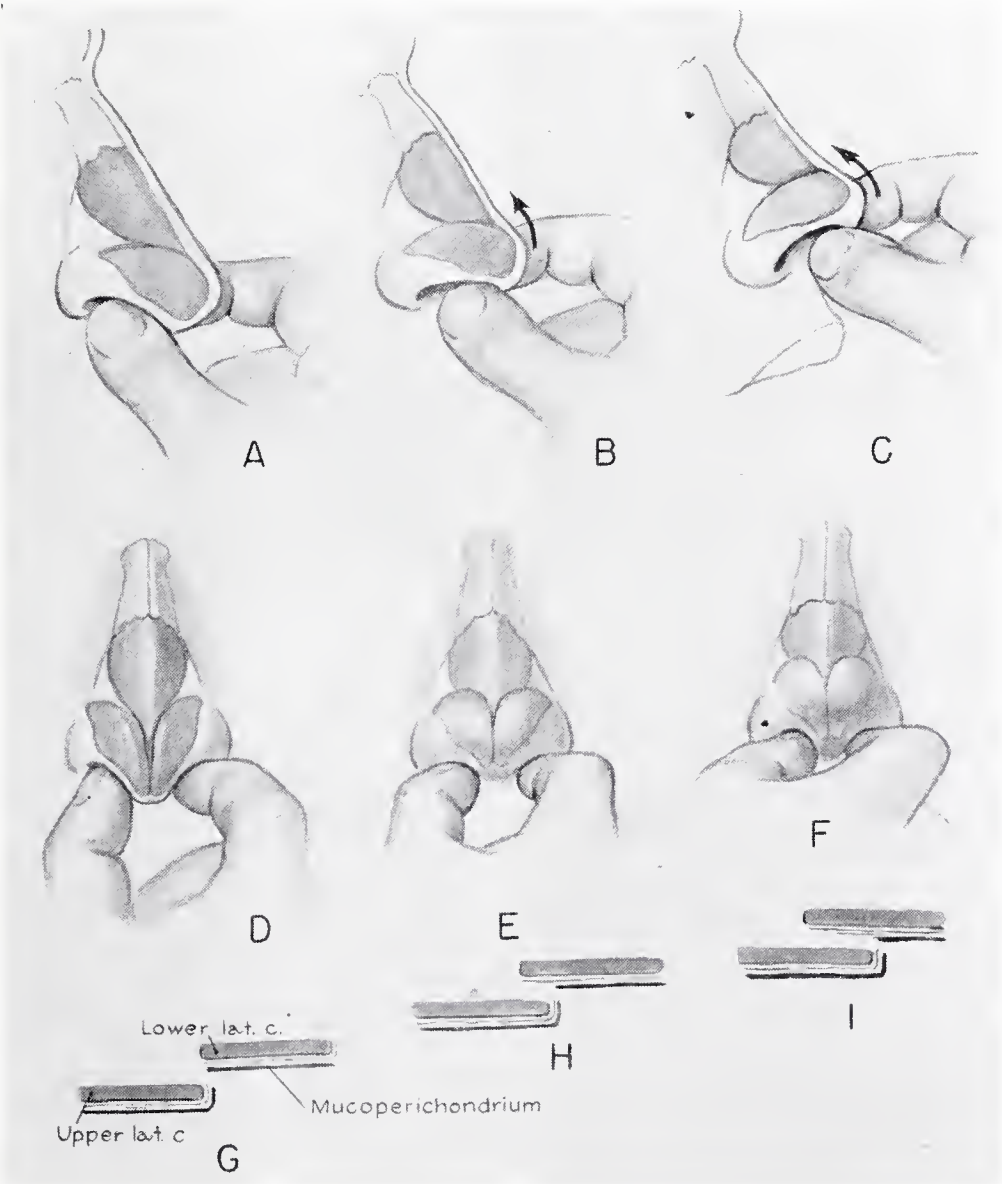


Fig. 17—Shortening of nose by superimposition of lower cartilaginous vault over upper. A, columella grasped between thumb and forefinger; B and C, lower cartilaginous vault rotated over upper; D, E and F, serial frontal views; G, H and I, sagittal sections, showing relation of aponeurosis between upper and lower lateral cartilages.

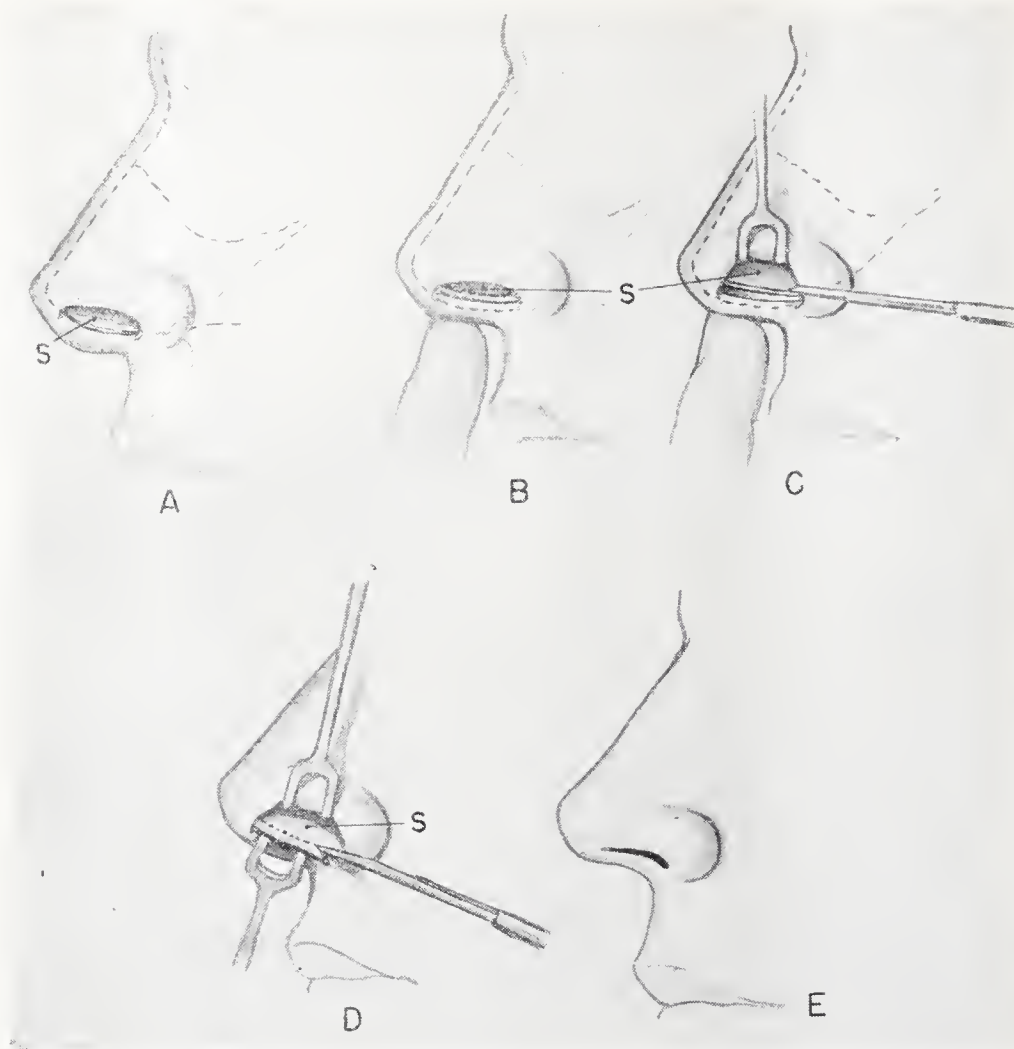


Fig. 18—Method of ascertaining projection and inclination of columella after rotation of cartilages. A, hanging columella, due to projecting septum; B, columella raised along side of septum, to obtain normal projection and inclination; C, ala retracted, and amount of cartilage to be excised marked out with knife; D, cartilage excised; E, result following excision.

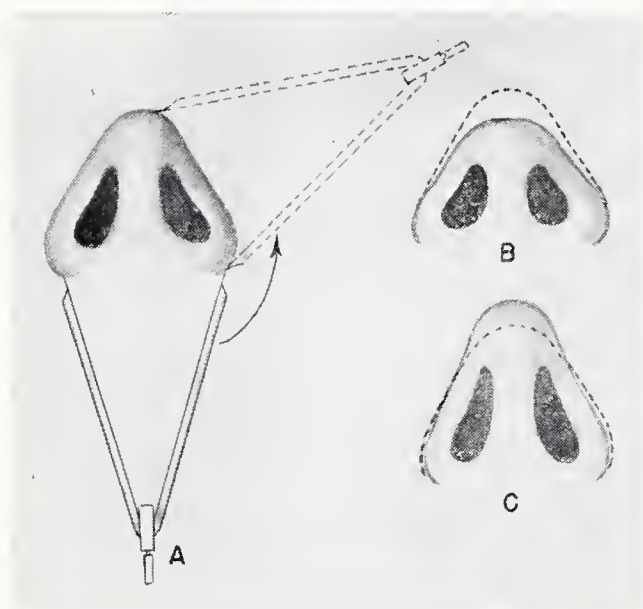


Fig. 19—Measurement of base of nose with calipers. A, points of calipers placed at junction of alae with lip. Dotted line indicates one point of calipers swung to midline. If it falls on center of tip, projection is normal. B, if point of calipers lies above center, tip is unduly receding. C, if point of calipers lies below center, tip is unduly projecting.

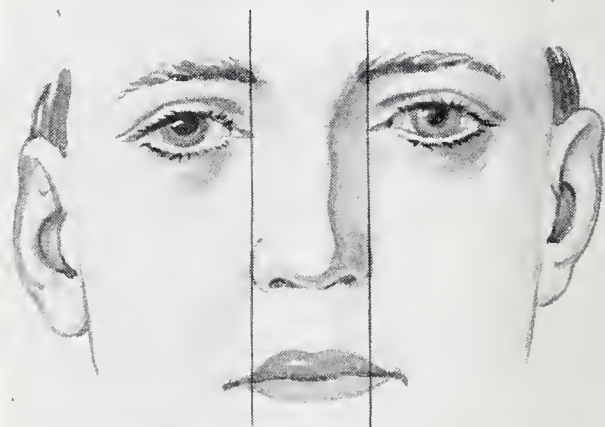


Fig. 20—Dropping of parallel perpendicular lines from inner canthi. Lines should be tangential to alae.

bring the alae within these lines. The alae are cut through where they abut the lip, and through these incisions the base of the nose is separated from its attachment to the bone. An absorbable surgical suture threaded through two straight needles is passed through the tissues, entered through one incision, and brought out through the other (Figure 21). The suture is tightened, to secure the desired width, and tied. This suture also serves to project the septolabial junction and elongate the columella. The two alar incisions are closed with two or three atraumatic sutures.

Reconstruction of Side Walls (Alae) (Figure 22): If the lateral walls are misshapen and/or of abnormal length, the lateral crura are delivered in the usual manner, and the soft tissue over the cartilage is removed. A small flap of vestibular skin is raised from the terminal end of the cartilage, its size depending on how much of the crura will overlap. This prevents the burying of epithelium. In addition, the small flap provides a cover for the raw area at the apex of the vestibule. The balance of the cartilage is shaved and/or cross-hatched until the spring has been completely destroyed. The vestibular surface of the flap is examined (Figure 23). Usually there is enough raw area to permit an adequate adhesion between the

upper and lower cartilaginous vaults. Should it be deemed advisable to secure broader adhesion, the vestibular skin is undermined, but not removed. It will automatically retract, to produce the desired result. Further modeling is done during the tip reconstruction.

Reconstruction of Apex of Lobule (Tip) (Figure 24): The cut ends of the mesial crura are delivered. If cleft or separated, they are brought together with an absorbable surgical suture. Occasionally the intervening soft tissue must be removed before approximation can be obtained.

The ends of the lateral crura are then grasped

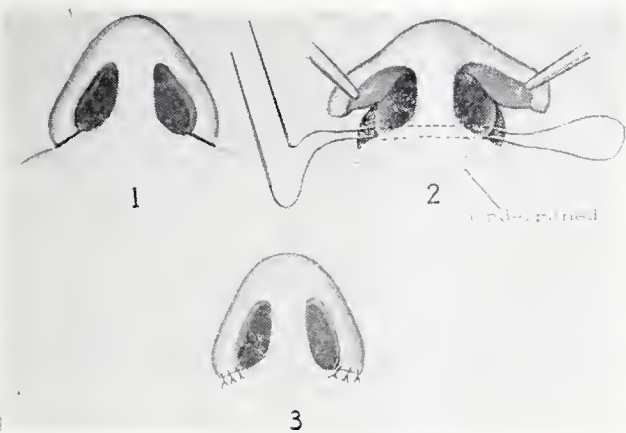


Fig. 21—Reconstruction of retracted septolabial angle with wide alar base. 1, alae separated from lip; 2, base of nose separated from underlying bone; dotted area indicates amount of undermining; absorbable surgical suture passed through tissues and then tied; 3, alar incisions closed.

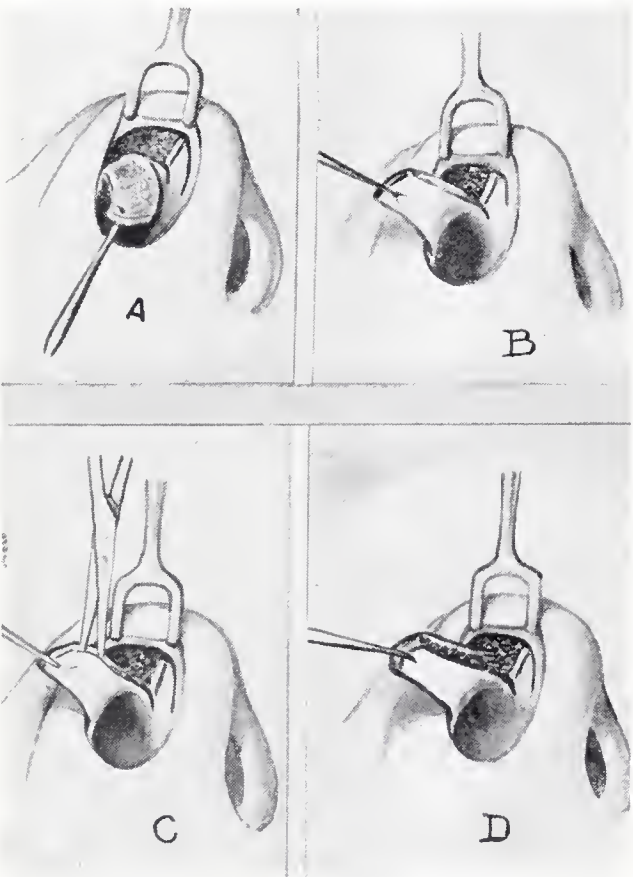


Fig. 23—Examination of vestibular surface of flap. A, lateral crus delivered, raw surface facing outward. B, lateral crus turned over, to bring vestibular surface into view. Note amount of raw surface for adhesion between upper and lower cartilaginous vaults. C, to secure broader adhesion, vestibular skin undermined with scissors but not removed. D, greater amount of raw surface for adhesion visible.



Fig. 22—Modeling of lateral crura. A, soft tissue over cartilage removed; B, flap of vestibular skin raised; C, cross-cuts made through cartilage, to break spring; D, section of cartilage peeled off when deformity results from faults in shape and excess bulk.

in turn with forceps and placed over the mesial crura (Figure 25), the two ends being made to abut or overlap each other. With all the parts mobilized (cover, support and lining), the lobule is modeled with the fingers, as one would shape a

piece of clay, until the desired contour has been attained (Figure 26).

The normal "break" above the tip is created at the conclusion of the operation by elevation of the ends of the lateral crura and draping of the

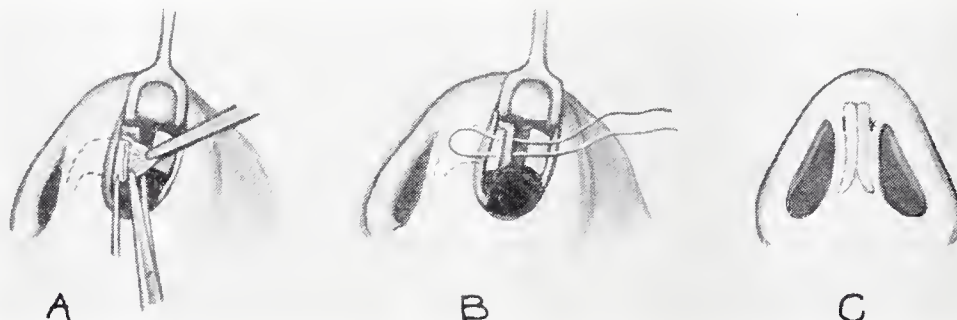


Fig. 24—Modeling of mesial crura. A, both mesial crura exposed through left nostril, and intervening soft tissue removed; B, crura approximated by through-and-through mattress suture; C, suture tied.

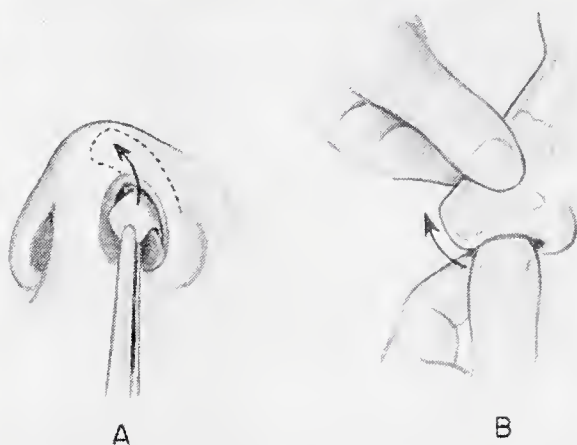


Fig. 25—Modeling of lateral crura. A, free end of lateral crus grasped with forceps and dislocated downward into tip, to create break above lobule; B, with fingers of left hand above lobule and those of right hand grasping columella, ends of lateral crura forced over mesial crura.

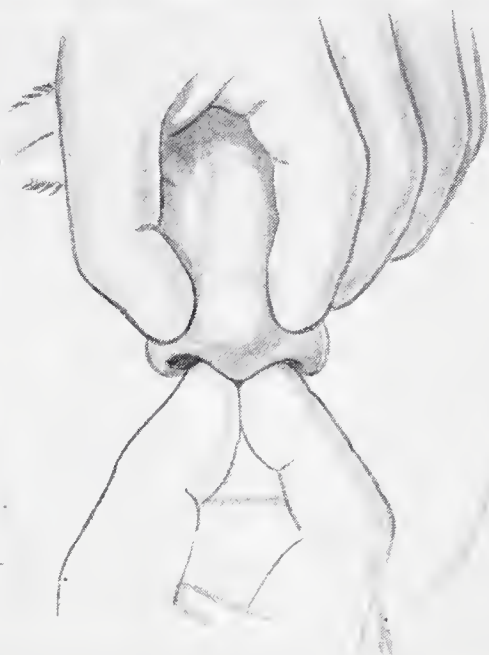


Fig. 26—Adjustment of soft tissues. Covering flap of skin and subcutaneous tissue and lining flap of vestibular skin and cartilage manipulated into desired relationship.

soft tissues of the lobule over them in the following manner (Figure 27): A pocket is made between the skin and mesial crura. Into this pocket is inserted a strut consisting of part of the removed hump or septal cartilage. The strut is placed in such a manner as to force the ends of the lateral crura upward sufficiently to attain the proper "break" between the tip and the dorsum.

MODELING OF APEX OF PYRAMID (Nasal Root)

For surgical purposes the apex, or root, constitutes the upper one-quarter of the nasal pyramid. In a normal nose the distance from the inner canthus to the midpoint of the frontonasal articulation (nasion) should measure approximately three-quarters of the length of the base. Unlike the balance of the nose, the root is a solid block of bone all the way back to the cribriform plate. This makes it impossible to narrow the base by shifting the walls medialward. Chiseling out the center of the block to create room for shifting is

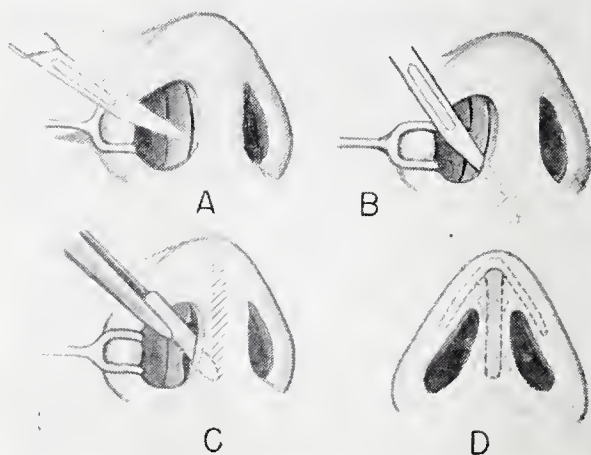


Fig. 27—Elevation of terminal ends of lateral crura by batten. A, incision along mesial crus extended; B, pocket made between skin and caudal margin of mesial crura; C, batten introduced; D, relationship of batten to lateral crura.

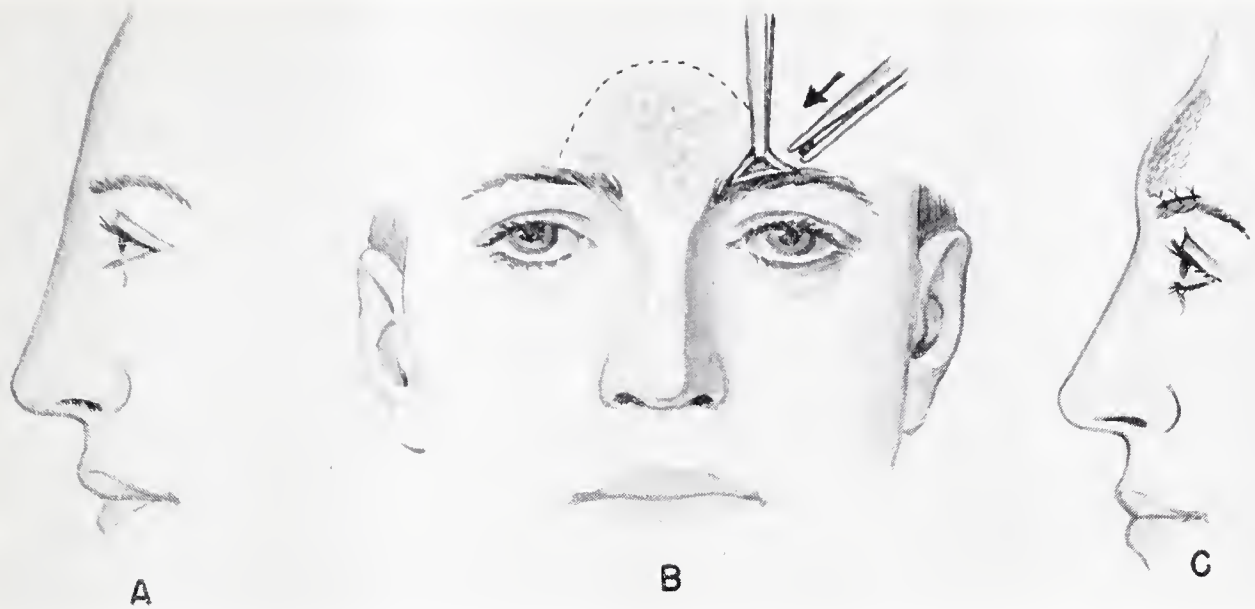


Fig. 28—Shallow nasofrontal angle (Greek profile). A, due to receding forehead. B, incision made in eyebrow. Dotted line indicates amount of undermining. Forceps shown introducing fragmented cartilage or bone. C, profile view of completed operation. Wound in eyebrow closed.

ineffectual, because not enough bone can be safely sacrificed to allow the side walls to meet. Nor can the projection of the side walls be reduced by their displacement into the nasal fossae. Being of solid structure, however, the apex of the pyramid can be shaped by a chiseling of the outer surface.

Since the back wall of this section is a fixed measurement (intercanthal line), it cannot be altered. Only the side walls are subject to modeling.

Side Walls Too Long. If the side walls are too long, a saw-cut is made at the desired level on either side in the manner employed for the removal of a hump. With a chisel these grooves are deepened to meet below, and the bone is rocked out with a hemostat. If the projection is entirely nasal, it will come away easily in one piece at the nasofrontal articulation; if it is due to the nasal process of the frontal bone, some difficulty will be encountered, and the bone will require piecemeal resection. The root is then made to resume its pyramidal contour by a chiseling down of the sides. A practical expedient is to cut the root down and replace it with a modeled graft.

Side Walls Too Short. If the side walls are too short, the solution is a simple one—namely, the introduction of a graft.

Simulated Root Deformities Due to Faults in Frontal Bone. In a normal profile the angle between the forehead and the root should be 125 degrees.

Receding Forehead: A receding forehead may give rise to an unduly shallow angle. Under such

circumstances the glabellar region must be built up with a graft to form a normal angle (Figure 28). An incision is made in the eyebrow and a pocket created over the glabella in the plane immediately above the pericranium. Chips of cancellous bone or cartilage are introduced and manipulated with the fingers until the desired nasofrontal angle is obtained. The small incision in the eyebrow is closed with atraumatic sutures.

Projecting Forehead: A projecting frontal bone may cause the angle to be too deep. Correction of this deformity still awaits a satisfactory solution.

MODELING OF BODY OF PYRAMID (Osseous and Upper Cartilaginous Vault)

The body of the pyramid is composed of a thin shell of bone and cartilage, divided by a fixed bony and cartilaginous central partition (septum). Here the anatomy is such that the walls can readily be shifted medialward or backward.

In this segment correction may be necessary for one or more of the following deformities:

Undue Projection (Hump). The steps in the reconstruction comprise: (1) reduction of the profile projection (hump removal) and (2) reconversion of the resulting trapezoid into a triangle by an inclination of the walls medialward. The base and apex of the pyramid having been corrected, the proper projection of the body of the pyramid can be easily ascertained by a straight line drawn with methylene blue on the skin on either side of the nose from root to tip (Figure 29). Any part



Fig. 29—Normal projection of body of pyramid ascertained by straight line drawn from root to tip. Any part of dorsum above this line requires removal.

of the dorsum appearing above these lines requires removal.

Reduction of Profile Projection (Hump Removal)

The left ala is retracted and the incision in the plica nasi located. A left bayonet saw is then introduced (Figure 30). The instrument is advanced to the nasofrontal suture, with the teeth directed dorsally. The teeth are now turned at right angles to the nasal wall, and the saw is placed against the bone at a level to attain the desired profile angle.

With the fingers of the left hand the apex of the saw is fixed. With the handle of the saw held in the right hand, wrist and elbow rigid, the bone is cut through, the shoulder joint being used as a fulcrum. When the bone has been cut through, the handle is shifted obliquely and the sawing continued through the perpendicular plate of the ethmoid. When this has been accomplished, the tip of the saw will be felt at the nasal root on the opposite side (Figure 30). The left saw is now removed, the right ala retracted and the right saw introduced in the same manner, its point be-

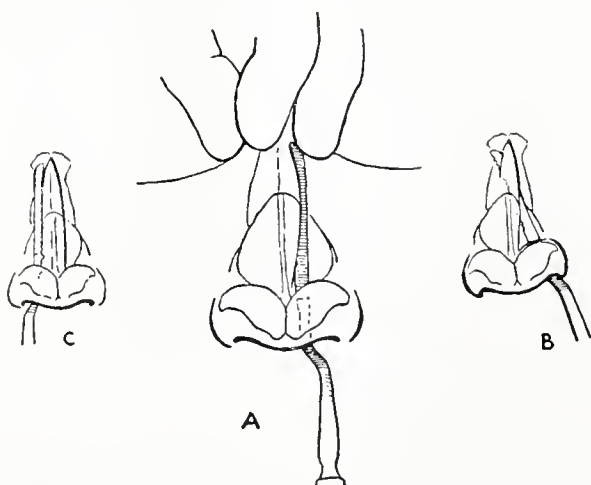


Fig. 30—Removal of hump. A, left saw placed against bone at level to attain desired profile angle. B, left nasal bone and perpendicular plate of ethmoid cut through. Niche made in right nasal bone. C, saw-cut through right nasal bone completed.

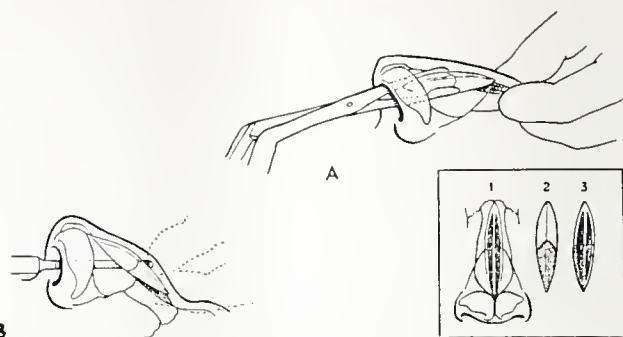


Fig. 31—Removal of hump (cont'd). A, cartilaginous hump cut through with button-end knife and extracted with forceps; B, hump palpated for detection of any asymmetry; 1, appearance of dorsum after removal of hump; 2, ectal surface; 3, ental surface.

ing fixed in a niche at the root made by the left saw.

The saw is now placed against the right nasal bone at the same level as the saw-cut on the left side, the level being checked by palpation of the left groove. The bone is then sawn through (Figure 30). Palpation will disclose that the bony hump is now free and the cartilaginous hump fixed.

The left nostril is next retracted and a short button-end knife introduced into the vestibular incision (Figure 31), its blade being inserted beneath the severed bony hump. The knife is drawn down, and the cartilaginous portion of the hump is cut away from the upper lateral and septal cartilages, the same level being maintained throughout, until the instrument falls free into the transfixion incision (Figure 31). The hump is now extracted with a hemostat or Knight forceps (Figure 31A).

The nasal dorsum is then palpated, attention being directed to the central ridge formed by the perpendicular plate of the ethmoid and the septal cartilage, and to the two lateral ridges composed of the frontal processes of the maxillae and the upper lateral cartilages (Figure 31B). The hump is examined for symmetry. In the event of a bony asymmetry, a Fomon rasp is passed through the

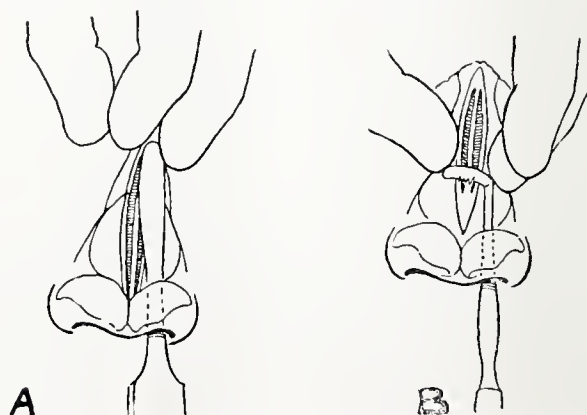


Fig. 32—Leveling of bony and cartilaginous dorsum for asymmetry. A, bony margins polished with rasp; B, cartilaginous margins pared with angulated knife.

left vestibular incision, and filing is continued until the plane of the dorsum is even (Figure 32A). If the sides of the cartilaginous hump are asymmetrical, a right-angled cartilage knife is introduced and the projecting side pared until it equals its fellow (Figure 32B). The bone dust, spicules, and other debris are then removed with a sweeper.

Finally, an angulated nasal speculum is introduced, light is thrown into the nose, and the dorsum is inspected.

Reconversion of Resulting Trapezoid into Triangle by Inclination of Walls Medialward

The cross-sectional trapezoid resulting from the hump removal is reconverted into a triangle by means of osteotomies through the frontal processes of the maxillae and a tilting of the lateral walls medialward.

An angulated speculum is introduced between the soft tissues and the upper cartilaginous vault, the instrument being used as a guard. A No. 11 Bard Parker knife separates the upper lateral cartilages from the septum (Figure 33). If necessary,

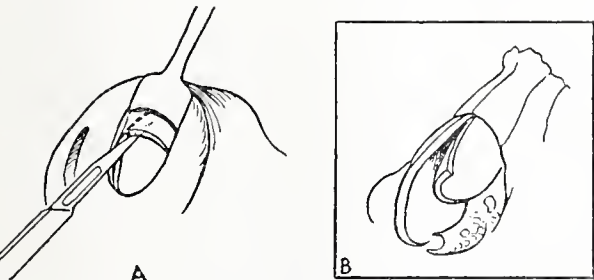


Fig. 33—Reconversion of trapezoid into triangle. A, angle between septum and upper lateral cartilage cut through with Bard Parker No. 11 knife, angulated retractor serving as guard; B, appearance of cartilages after division.

the spring of the nasal bones is broken by a chisel passed between the nasal bones and septum. The procedure is repeated on the opposite side.

The left ala is now retracted and the lateral margin of the piriform aperture (point below alar-facial junction) located. With a No. 11 Bard Parker knife the overlying mucosa is incised down to the bone (Figure 34).

A MacKenty elevator is introduced beneath the periosteum, and the overlying tissues are raised en masse from the nasofacial groove to a point midway between the nasion and the inner canthus (Figure 35). The extent of elevation should be no more than for the comfortable admission of the saw or chisel.

A grooved director or MacKenty elevator is introduced into the incision made along the margin of the piriform opening (Figure 36). With this as a guide, a left right-angled saw is passed into the periposteal pocket, teeth directed down-

ward. The elevator is then removed and the saw turned in such a way that the teeth lie at right angles to the bone (Figure 37). The instrument is manipulated until it falls into the nasofacial groove, its apex lying at a point just below and medial to the inner canthus and its base at the outermost margin of the piriform opening (Figure 37). The fingers of the left hand are placed over the apex of the saw, to fix it and protect the inner canthus.

With several up-and-down strokes the bone is cut through 2/3 its thickness. Under no circum-

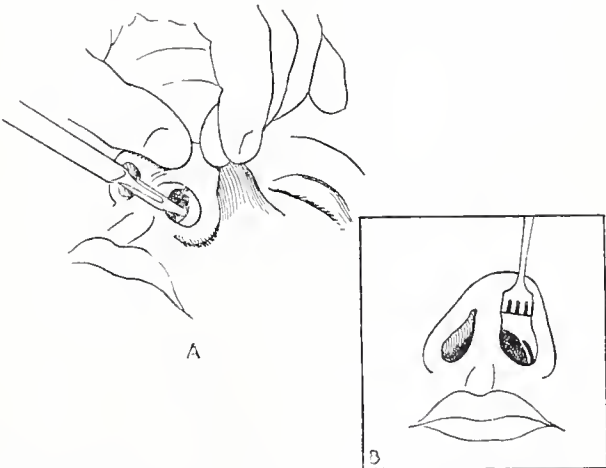


Fig. 34—Lateral osteotomy. A, mucosa overlying lateral margin of piriform opening incised with Bard Parker No. 11 knife; B, line of incision.

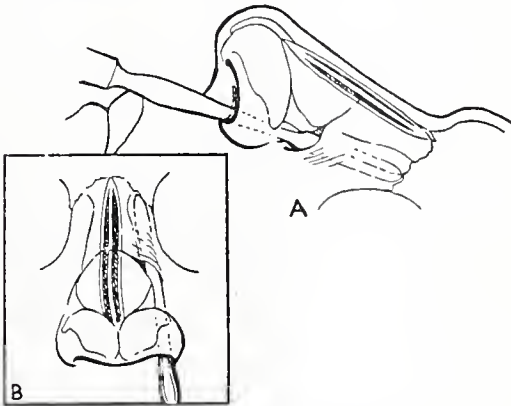


Fig. 35—Lateral osteotomy (cont'd). A, elevator introduced beneath periosteum, and tissues raised en masse over line of proposed saw-cut; B, ventral view.

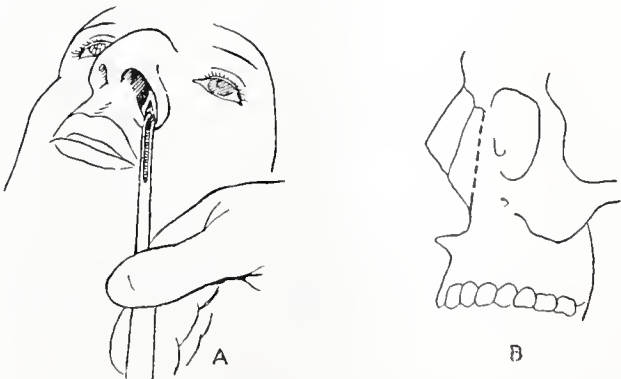


Fig. 36—Lateral osteotomy (cont'd). A, grooved director introduced into incision along margin of piriform opening; B, line of saw-cut indicated by dotted line.

stances should it be cut all the way through (Figure 37).

A guarded chisel is introduced, the saw-cut extended to the nasofrontal angle and the articulation cut through. The procedure is repeated on the right side.

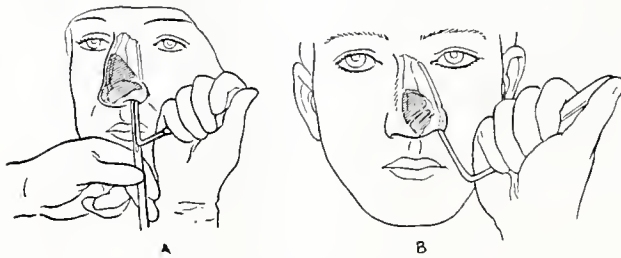


Fig. 37—Lateral osteotomy (cont'd). A, saw, guided by grooved director, introduced into periosteal pocket. B, saw engaged along nasofacial groove, apex midway between inner canthus and nasion, and base resting on outermost margin of piriform opening. Bone cut 2/3 through.

With the operator now standing on the left side of the patient, a pad of gauze is placed over the left nasal wall. Both thumbs are braced over the gauze, and with moderate pressure the nasal walls are forced to the midline (Figure 38). The procedure is repeated on the opposite side.

A Walsham forceps is now introduced, and the left nasal wall is rotated into the nasal fossa. The procedure is repeated on the opposite side (Fig-

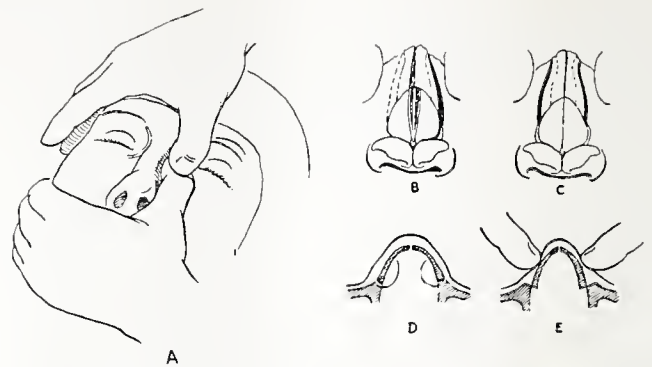


Fig. 38—Infrafracturing of nasal wall. A, bones brought to median line by thumb pressure; B, one wall shifted inward; C, appearance after infrafracture of both walls; D and E, sectional views.

ure 39). By elevation or depression of the fragments precise reduction is obtained, in accordance with the analyzed photographs and cast.

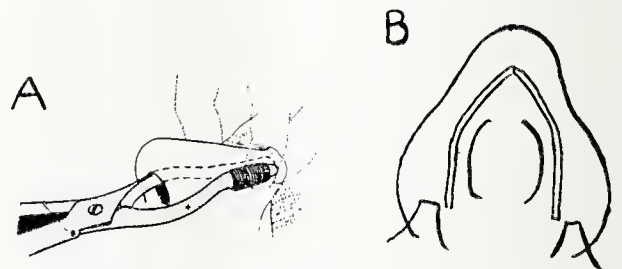


Fig. 39—Prevention of postoperative broadening by shifting of frontal process beneath maxilla. A, Walsham forceps made to dislocate lateral wall beneath maxilla; B, diagrammatic representation.

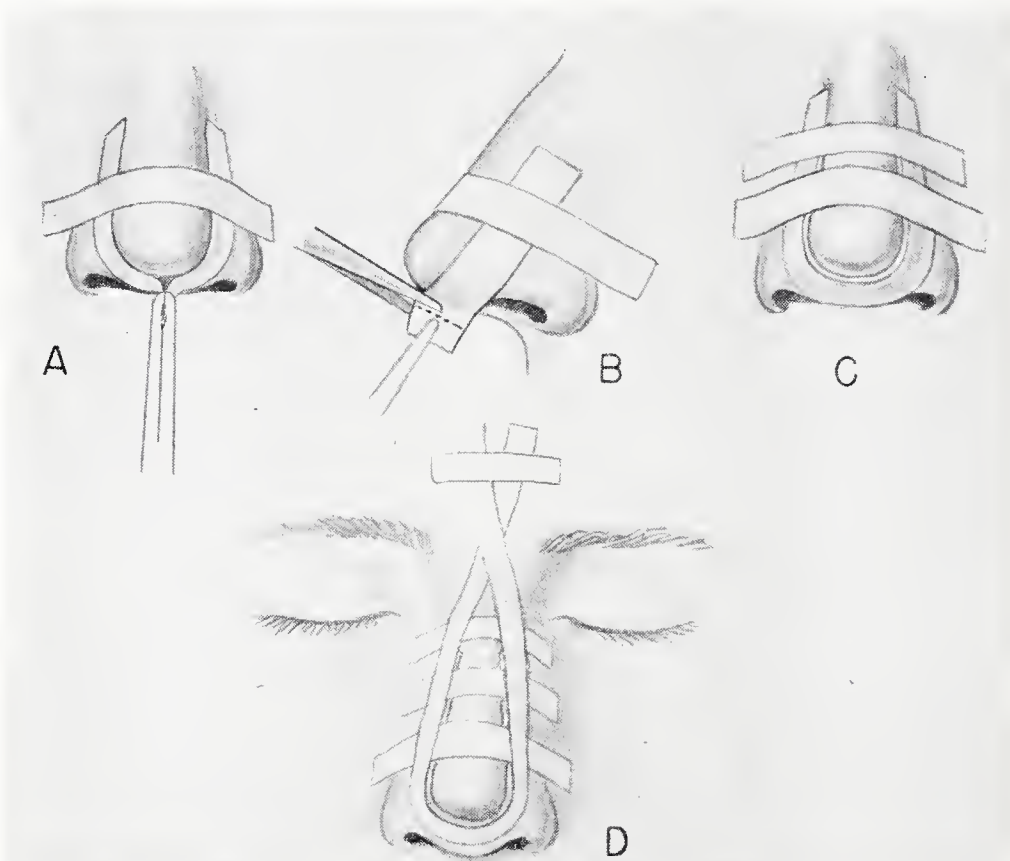


Fig. 40—Dressing. A, strip of adhesive plaster made to encircle base of lobule, another strip applied over dorsum just above batten, and plaster pinched up beneath lobule to force batten into proper position. B, pinched-up tuck excised; C, adhesive plaster reinforced by additional strips; D, sling support.

The unduly projecting bony septum between the fragments is now excised, either with a chisel or with a bone-cutting forceps. The septum and upper lateral cartilages are trimmed with angulated scissors, to secure the desired cartilaginous profile projection.

Deficient Projection. The part is built out with a cancellous bone graft in the usual manner.

Deflection. If the body of the pyramid is deflected, the broad side is reduced to equal the short side, osteotomies are made through the frontal processes, and the walls are shifted to the midline.

Broad Nose. The correction depends on the cause. If the base is broad but the lateral walls are of proper length, the base is narrowed as follows: The spring of the arch is broken, osteotomies are performed through the frontal processes, and the lateral walls are shifted medially.

DRESSING

The nostrils are lightly packed with petrolatum gauze, to hold the flaps in place. The shape of the nose is maintained with adhesive strips, which act as a mold in which the mobilized tissues heal, similarly to the congealing of jelly poured into a container. The length of the nose is controlled by a sling extending from the lobule to a point on the forehead (Figure 40).

A piece of flannel is cut in the form of a butterfly and covered with softened Stent. The flannel-lined Stent is then molded to the nose and held in place until it hardens, when it is fixed by strips of 1/2 inch adhesive running obliquely from the forehead to the cheek and horizontally from cheek to cheek. A small pad of gauze is strapped over the base of the nose to absorb any oozing (Figures 40 and 41).

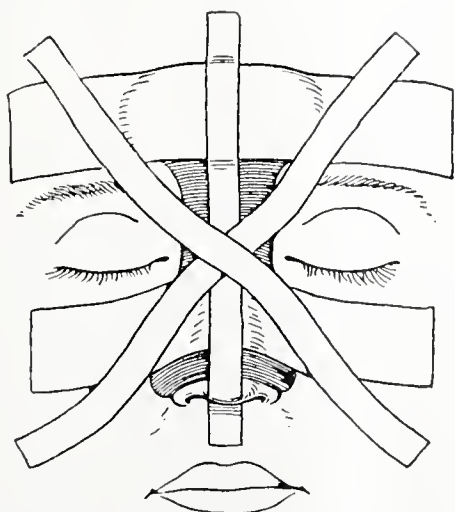


Fig. 41—Dressing (cont'd). Flannel-lined Stent molded to reconstructed nose and held in place with adhesive strips.

POSTOPERATIVE MANAGEMENT

The patient is placed flat on the back, with sandbags applied to either side of the head. A semisolid diet is prescribed for the first 24 hours. No visitors are allowed, and advice is given to avoid talking, laughing, etc. The hands are restrained at night, and in cases of discomfort or restlessness, luminal gr. 1-2, codein gr. 1/4 or aspirin gr. 5-10 are administered.

The patient is visited twice daily, at which time temperature, pulse and respiration are noted. A rise in temperature of 1 degree, which gradually falls within the first 48 hours, is of no consequence.

The dressing is removed on the 7th or 8th day. With an applicator dipped in benzene the adhesive is gradually separated and the splint carefully lifted from the nose, the manipulation being performed from above downward.

A few drops of sterile oil or hydrogen peroxid are instilled into each nostril, and the xeroform packs are gently withdrawn, care being taken to avoid pulling, as it may displace the flaps. If the gauze sticks despite the use of oil or peroxid, it is left in place for another day.

The nose is smeared with mineral oil, covered with a pad of gauze and palpated. At this stage the nasal elements may be shifted and reassembled, should they be found out of alignment.

AMA SPONSORS CONFERENCE ON HAZARDS OF CHEMICALS

Thousands of common home, industrial and agricultural chemicals may be potential killers. To insure proper handling of these products, the AMA's Committee on Toxicology and Committee on Pesticides will sponsor a symposium on health hazards of chemicals in Atlanta on December 29 during the annual meeting of the American Association for the Advancement of Science. Representatives of the Food and Drug Administration, U. S. Public Health Service, Preventable Diseases Service of the Georgia Department of Health, and the AMA Committee on Cosmetics, as well as many physicians, will be in attendance.—AMA Newsletter.

This Hazards of Chemicals would be an excellent theme for a coming Rural Health Conference: "Industrial Hazards on the Farm."

DOCTORS RAISE BIG FAMILIES

Despite the rigors of medical practice, physicians are family men, points out the October issue of Medical Economics. A cross-country survey conducted by the publication turned up the fact that the typical medical father has three children and that 18 per cent have four or more children.

THE GENERAL PRACTITIONER AND STERILITY PROBLEMS *

JAMES HENRY FERGUSON, Miami, Florida †

There are many contributions that the general practitioner can make to the solution of sterility problems before it is necessary to seek the assistance of the specialist. We all know well that the general practitioner himself can solve the case in many instances. Oftentimes the specialist, in his zeal for more complicated examinations and his absorbing interest in new devices and new therapies, overlooks the simpler and more obvious barriers to conception. I recently saw a striking example of the neglect of a preliminary and basic effort against infertility. In a sterility clinic conducted by residents in obstetrics and gynecology and specialists in that branch we had become too engrossed in X-ray visualization of the Fallopian tubes, the use of new medicines, and other refinements in the study of the sterile woman. We had neglected to point out to many women that conception can take place in only a relatively short span of the menstrual cycle, and if coitus does not take place at the right time they will never get pregnant. In a personally conducted spot check I found that over 50 per cent of the women in the clinic did not know that there was a fertile time of the month, or if they knew there was a fertile time, their information on the subject was grossly incorrect; as is a common experience, regardless of social or geographic grouping, many had been instinctively self-advised, or incorrectly counseled by other women, that the fertile days were immediately before and immediately after menstruation. We know the truth is the exact opposite.

Many couples need only some simple procedures and common sense advice to overcome their childlessness. The average practitioner does not possess the instruments nor the interest to undertake the more specialized studies of the infertile couple but if he will adhere to some simple, sound concepts of the management of sterility, the wife will often get pregnant before she gets to the specialist. By the more specialized studies I mean for example, endometrial biopsy, salpingography and tubal insufflations. A frequent experience for men who are interested in sterility work is to see the women conceive soon after the first visit or before the work-up is anywhere near completed; this is expressive of the almost unaccountable effectiveness of introductory discus-

sion and ordinary general and pelvic examination. Here in some cases undoubtedly is an example of the powerful, unplumbed psychic forces that are at work in fertility and infertility. There is something potent in getting started on a scientific study of the problem and on finding a physician who lights one's hope. A very common comment of infertile couples is that they never have found a doctor who was really interested in their dilemma.

For a preliminary survey of the sterile couple, the only special equipment that is needed is a microscope. There should be a systematic search for and elimination of the simple and common things that can prevent conception. I have found that there is a wide-spread tendency to begin the management of the infertile couple with hormones and vitamins and to make these two groups of medicines the mainstays of the treatment. Unless one of the couple is clearly lacking in some vitamin or hormone we have not been able to put any of these medicines to consistent proved usefulness. Polyhormonal and polyvitamin preparations have their greatest usefulness as psychic therapy, due to the undeserved high opinion so many laymen have of them. Some hormones can have a sterilizing effect rather than a fertilizing effect.

The husband and wife will be helped by at least a rudimentary knowledge of the anatomy and physiology of the reproductive process. We doctors constantly have to fight our tendency to assume that the patients know more about their bodies than they actually do. A safe beginning in sterility work is to assume that the patients know nothing. Many times the sophisticated patient will beguile us into thinking she is a Ph.D. in reproduction whereas in truth her mother did not allow her to go to grammar school. Your instruction can be carried out by charts and other visual aids. A book on the subject would be a great help.

A complete history taking and physical examination must be done early and both partners should be brought to the highest level of mental and physical health that is possible. Mental health should include confidence as long as you can justifiably offer it to the patient. That length of time can be almost forever. Is there anyone here who has not had a parous woman say to him that Dr. So-and-so told her she would never get pregnant? Physical health should include at-

* Presented at the 79th annual session, Arkansas Medical Society, Hot Springs, Arkansas, May 30, 1955.

† From the Department of Obstetrics and Gynecology, School of Medicine, Tulane University.

tempts at the elimination and improvement of all defects. Prominent among these would be vaginitis, cervicitis, obesity, and anemia. Excesses in alcohol and tobacco are widely indicted as antagonists of effective germ tissue. Combined mental and physical benefits will result from regulation of living habits, and sane programs of work and play. Too many conceptions have taken place during vacations to have been entirely coincidence.

I purposely repeat that each partner should understand when the fertile days of the month occur and the importance of having intercourse at that time. Most women ovulate on or close to the 14th day before the day menstruation begins. A clear appreciation that intercourse must be grouped around that day is imperative. There is not the time today to take up basal temperature charts and they may be of secondary importance. A basal temperature chart will establish whether or not the patient ovulated in a particular menstrual month. If she does not ovulate, what we have to offer is very discouraging. So many women know about temperature charts and have somewhere picked up an unmerited appreciation of them that the keeping of a temperature chart for a while should not be discouraged. The temperature chart may not be much of a help but as one realistic and disillusioned scientist said, "Well, anyway it gives them something to do."

The coital habits of the couple should be checked to eliminate any unsatisfactory practices. In my experience the most frequent shortcomings have been postcoital douching and rising to empty the bladder. Amazing as it may seem to us there are many women who are genuinely desirous of getting pregnant and who take a douch immediately after intercourse. This is just another evidence of their lack of basic information. We will never learn of this practice without aimful questioning. Precoital douching, except with special sperm-sustaining agents, is also taboo. Postcoital voiding, and all other activities which cause semen to escape from the vagina, is undesirable. This is an extremely common practice and patients rarely volunteer information on it. A little self-control and possibly restriction of fluids are all that are needed. Subsequent placing of pillows under the hips and reclining quietly in bed for at least thirty minutes have an opposite and desirable effect.

An indispensable part of a good job is the microscopic examination of the semen. Although it is usually the woman who initiates the investigation we must always remember that the husband as frequently, or almost as frequently, is wholly or

partially to blame for the lack of issue. The details of semen examination can be found in any good laboratory manual. The most vital parts of the semen examination are the sperm count as determined in a red blood cell counting chamber and the observation of the per cent of the sperm that are active. The postcoital test is a variant of this examination and involves the study of the vaginal and cervical canal fluid at some interval of hours after coitus. The postcoital test may be more convenient for the male but, in my experience, is considerably less informative than the examination of semen taken from a clean jar.

LAWS PERTAINING TO MEDICINE

LEGISLATIVE SESSION OF 1955

PETER DEISCH, Helena

- Act 65:** Creates medical examining board, consisting of 9 members, 6 from Congressional districts, 1 at large on recommendation of Arkansas Medical Society; 1 on recommendation of Eclectic Medical Society, and 1 appointed on recommendation of the Examining board, the latter to be Secretary.
- Act 69:** Medical student loans, who will practice in community of not more than 2,000, for 5 years. Each year of such practice reduces loan 20%.
- Act 107:** Practice of medicine includes "diagnosis and treatment of mental and nervous diseases and disorders."
- Act 129:** Board of Psychologists created.
- Act 155:** Uniform narcotic drug act. Heretofore paregoric could be sold by pharmacists; now must have prescription of physician, dentist or veterinarian, and they only can issue prescriptions for narcotics.
- Act 161:** Requiring isolation of recalcitrant T.B. patients.
- Act 172:** Autopsies may be performed when consent is given by the relative or friend who is charged with responsibility for burial. Permission from 1 person is sufficient.
- Act 217:** Medical Center appropriation: 10 staff members at \$18,000; 5 at \$16,000; 8 at \$15,000; 13 at \$12,500; 12 at \$10,000, and others. Total salaries \$1,650,000; maintenance \$850,000; building and capital improvements \$3,000,000, for 1955-56 period. Salaries \$2,450,000; maintenance \$1,050,000;

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For nearly two years, ACHROMYCIN has been in daily use. Thousands of practicing physicians in every field have substantiated its advantages, and the confirmations mount every day.

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wide-spectrum activity

prompt control of infection

rapid diffusion

negligible side effects

buildings and capital improvements \$2,000,-000, for 1956-57 period. NOTE: if the percentage of revenues do not provide those amounts it cannot be spent.

Act 287: Basic science appropriation.

Act 298: Medical consultant to Department of Public Welfare, \$4,200.

Act 301: Cancer Commission appropriation: Salaries \$11,040; maintenance \$1,750; aid \$40,000.

Act 304: Appropriation for anti-T.B. drugs for those unable to pay for them at Booneville.

Act 357: BARBITURATES: Physicians shall keep record of those administered, but no record of drugs administered to any 1 person for not more than 8 grains in 24 hours. No record need be kept of prescriptions.

Act 363: Division of Hospitals, State Health service; surveys; application for Federal funds.

Act 411: Alcoholism study. 1 or 2 of the 7-members board, shall be physicians.

Act 423: Qualifications of Superintendent of State Hospital.

Act 428: A member of the Basic Science Board, who is an employee of the State may receive per diem in addition to his salary.

RESOLUTIONS

WHEREAS, an all wise providence has seen fit to remove from our midst, Dr. J. A. Summers, who was our valued co-worker and a faithful member of the Pulaski County Medical Society, the Arkansas Medical Society, and the American Medical Association since 1923: We, the members of the Pulaski County Medical Society, mourn and deeply regret his sudden departure July 7, 1955.

WHEREAS, as a Physician in his chosen field of Public Health, he attained a great measure of distinction and won the respect and admiration of his colleagues, as well as the gratitude and love of a host of sorrowing people. Dr. Summers was connected with the County Health Department for many years as an active member and was respected and admired by all who knew him. He was also an active Masonic Member.

THEREFORE, be it resolved that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of this Society and its heartfelt sympathy to the family at the untimely loss which it has sustained.

BE IT FURTHER RESOLVED that a copy of this resolution be made a matter of record in the

minutes of the Pulaski County Medical Society; that a copy be sent to the family, and a copy to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

Paul Fulmer, Chairman
Joe F. Shuffield
Bryce Cummins
R. M. Eubanks

ADOPTED: November 7, 1955
Pulaski County Medical Society
Donaghey Building
Little Rock, Arkansas

WHEREAS, death has taken from our midst, Dr. George V. Lewis, who was a valued co-worker and a faithful member of the Pulaski County Medical Society, the Arkansas Medical Society and the American Medical Association since 1922, we, as members of the Pulaski County Medical Society mourn and deeply regret his departure. He was a contemporary of some, a close associate of many and a teacher to a host of present day doctors throughout the State and over the country as well. Dr. Lewis will, long after death, be remembered by these men for his favorably guiding influences and untiring efforts over many years of teaching and clinical guidance to younger men in their formative days.

THEREFORE, be it resolved that the Pulaski County Medical Society express to his family the esteem in which he was held in this Society, as a contemporary, an associate and a teacher of physicians, and that the Society express to the family its heartfelt sympathy for the loss that all have sustained;

BE IT FURTHER RESOLVED, that a copy of this resolution be made a matter of record in the minutes of the Pulaski County Medical Society; that a copy be sent to the family, and a copy to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

Robert Watson, Chairman
Alan G. Cazort
S. C. (Cy) Fulmer
J. Nye Compton
Grady W. Reagan
John E. Greutter
Edwin F. Gray

ADOPTED: November 7, 1955
Pulaski County Medical Society
Donaghey Building
Little Rock, Arkansas

— ★ Editorial ★ —

FAVORABLE PROGNOSIS IN VIRAL HEPATITIS

ALFRED KAHN, JR., Little Rock

During World War II the outbreaks of viral hepatitis focused great attention on these diseases, which previously had received relatively little investigation. Because of the almost epidemic number of cases, it became very important from a military manpower point of view to know the immediate prognosis of the disease, and from a financial point of view to determine the ultimate outcome of these jaundiced cases, which include infectious hepatitis and homologous serum hepatitis. The military cases proved that the immediate prognosis was relatively good, although series have been reported in which the immediate mortality was very high.

Speculation arose as to whether these diseases might not lead to cirrhosis or other chronic liver disease. Sinclair, (Proceedings of the 42nd Annual Meeting of the Medical Section of the American Life Convention 1954) has indicated the ultimate prognosis of virus hepatitis is good. His review of the literature includes the following information from other authors. Neefe is said to have estimated that only 0.6% of all acute infections associated with jaundice give rise to chronic disease. Dubin is quoted as follows: "In our series we have not yet seen an example of cirrhosis resulting from viral hepatitis proven by biopsies in both the early and late phases of the disease." Zieve found no greater incidence of functional and structural abnormalities in those who had viral hepatitis than in those who did not have these diseases. Sinclair's review also points out that some patients become carriers, and that some asymptomatic cases also become carriers; these individuals are a health threat to others but do not seem to pose a personal health problem.

From the point of view of insurability for life insurance, Sinclair recommends standard rates in acute hepatitis as soon as there is complete laboratory and clinical recovery. In prolonged (more than four months) cases or recurrent cases, standard rates might begin three years after complete recovery with penalty rates prior to that time.

There is still no adequate explanation of cirrhosis of the liver in many instances. Toxic substances have a clear relationship to liver scarring. On the other hand, these agents fail to explain alcoholic cirrhosis, which many feel may represent a deficiency disease. It was hoped that viral he-

patitis studies might uncover a relationship between this disease and cirrhosis, and although a few cases of viral hepatitis have been followed to a stage of scarring and profound injury to the cord cells, there is inadequate evidence to incriminate viral hepatitis as a significant cause of cirrhosis.

By and large, the prognosis in viral hepatitis is good despite isolated epidemics of fulminating disease and despite unfavorable reports when there are complicating conditions. Statistically, the outlook for complete recovery is excellent.

The Editorial Staff of the **Journal** wishes to each and every reader a Happy Christmas Season and prays for a New Year of opportunity to be opened and made full of accomplishment for all Arkansas physicians.

NOT ENOUGH

Arkansas physicians have yet to respond fully to the appeal of our medical schools for funds. Not enough of us have given to the American Medical Educational Fund. When we realize that for every dollar that Arkansas physicians contribute, many times that amount comes to the University of Arkansas Medical School. The Little Rock institution has received nearly \$100,000 in the past four years and our own physicians have contributed much less than one quarter of that amount. Below is a list of donors from our state, and the list is far too short.

Jessie Cavener, Little Rock; Edwin F. Gray, Little Rock; Polk County Medical Society, Mena; W. R. Brooksher, Fort Smith; J. H. McCurry, Cash; Woman's Auxiliary (Arkansas Medical Society), Little Rock; Troy Price, Strong; Cal Gunter, Siloam Springs; James Huskins, Siloam Springs; M. E. Blanton, Jonesboro; Hugh R. Edwards, Searcy; Fount Richardson, Fayetteville; R. H. Chappell, Texarkana; E. M. Gray, Mountain Home; C. Lewis Hyatt, Monticello; Robert F. Hyatt, Monticello; Carl L. Wilson, Fort Smith, and Morton C. Wilson, Fort Smith.

The time is NOW. Make out your check to:

A. M. E. F. (American Medical Education
Foundation)

c/o American Medical Association

535 N. Dearborn Street

Chicago, Illinois.

Individual liberty and guaranteed security cannot exist together. The very nature of a guarantee necessarily deprives someone of some of his liberty.

Liberty is not a God-given right. It comes only when someone is willing to stand up and fight against force, coercion and compulsion. Liberty is man-acquired.

Note: Senators McClellan of Arkansas and Stennis of Mississippi would probably be interested at this time in the travesty of "Flying Pay" during peace time especially, and at a time when flying is certainly a common form of travel. This discriminatory advantage of one service over another is due to be abandoned and will mean the saving of much money from "Flying Pay" as well the saving of millions of gallons of gasoline, machinery, and pilot hours, in maintaining the flying status of personnel for "Pay" purposes only. It's time some one looked into that particular form of leaking from the public coffers.

People cannot be free when a supposedly benevolent and paternalistic government plans their lives.

Arkansas

TRAVELING

And Clipping Bits Here and There

DEAN FREDRICK G. GILLICK

Creighton University School of Medicine, Omaha,
In South Dakota Journal of Medicine & Pharmacy

"Since the modern hospital is the workshop for physicians, the administration of such hospitals is intimately tied to the medical profession; not, however, to any segment of the medical profession, but to those members of the medical profession most competent through training, experience, and ideals to assist in the development of real hospitals. In almost any sizeable city over the country you have seen reactions by physicians to this changing concept. Perhaps not wisely, but in certain cities doctors' hospitals have sprung up and rumors are constantly heard to the effect that many of our present hospitals should change from the older concept to the present concept, or be replaced by institutions wholly governed by physicians.

"Nowhere in life does one find a group of people—physicians and hospital personnel—who have disciplined themselves so well and who voluntarily and constantly perform quality controls on their own work. I know of no other group who does as much so well and so effectively as this group. In spite of this, however, a 'gauze curtain' sometimes exists between the two groups. If we wish the best for patient care and the prevention of illness, this barrier must be torn away. In the instruction of medical students, our future physicians; in the instruction of nurses; in the instruction of all other personnel occupying key or critical spots in the hospital, the opportunity to

understand the activities of each should be presented. Without effective cooperation medicine will succumb to statism, without this cooperation the private hospital will cease to exist. The lure or lull of a munificent state—an all-powerful state—sounds like the tinkling of a cymbal in the distance while power is being acquired, but once the power is acquired, and this is done by transferring responsibility, the tinkling becomes the hammer of the smithy placing the steel band around our necks, placing us in a bondage from which escape is improbable. Legislatures exist to safeguard the rights of the citizens served; legislature cannot practice medicine.

"This bondage, as we have noted in other countries where the state no longer is the servant of the man, but man is the slave of the state, will encompass not alone the hospitals but also and eventually all things pertaining to the welfare of man, including the care of his health. Intelligent people, God fearing people, free people, can work out their destinies providing they accept and execute their responsibilities in full measure with justice to all. Under God, man is the master of his destiny; the state is man's servant or tool. Men who would remain free must never abdicate their heritage by shirking their responsibilities. True responsibility does not permit acceptance of only that which delights and rejection of that which is difficult. Responsibility in any given area is total and not selective. As soon as one is unwilling to accept his responsibilities and, by words or deeds, passes them on to others, one loses his freedom. The survival of the physician as a free agent and the hospital as a private charitable institution will depend on the ability of both the physician and the hospital to face the realities of responsibility."

ANNOUNCEMENTS

A Hobby Exhibit is planned for the meeting of the Arkansas Medical Society next April, from April 22 to April 25.

Those interested in exhibiting contact John McCullough Smith, Boyle Building, Little Rock.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 3, 1956. For further information write:

Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

Postgraduate Anaesthesiology is the most recent of the Graduate courses offered by the University of Arkansas School of Medicine. It was held November 18 and 19, and had as its feature speaker, Eugene H. Connor, Philadelphia, Assistant Professor of Anaesthesiology at the University of Pennsylvania. Little Rock specialists and anaesthetists from the Medical School constituted the faculty.

**A PROGRAM OF
CANCER FELLOWSHIPS AND RESIDENCIES**

**The University of Texas
M. D. Anderson Hospital and Tumor Institute
Houston**

Facilities and equipment for therapy and research in the field of malignant diseases are provided for qualified applicants seeking training and research opportunities in oncology: 80,000 feet of space devoted to research, clinics equipped to handle 100 new patients and 200 revisits daily, a Cobalt-60 Irradiator and Betatron, and radioactive isotope facilities. Fellowships and residencies are under the auspices of The University of Texas Postgraduate School of Medicine. Participation in Fundamental cancer research under able guidance, as well as a broad program of education in the Texas Medical Center, is offered in several divisions:

For further information and application forms write to Grant Taylor, M.D., Office of Education, The University of Texas M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25, Texas.

The Asamblea Nacional de Cirujanos (National Meeting of Surgeons) will be held in Mexico City, November 18-25, 1956. This is the most important meeting on medicine and surgery in Mexico, and takes place every two years.

Members of the International Academy of Proctology, The American College of Surgeons, The American College of Gastroenterology, and the American Gastroenterological Association, are cordially invited to attend this meeting.

There is always a large attendance as well by European and Latin American surgeons.

Dr. Alfred J. Cantor, International Secretary of the International Academy of Proctology, has been appointed the Honorary Vice-President of the Proctologic Section of this Assembly. Visiting Fellows of the International Academy of Proctology (to be announced later) will also serve as

Chairmen of some of the sessions, or Moderator of some of the symposiums.

**THE NEW ORLEANS GRADUATE
MEDICAL ASSEMBLY**

The nineteenth annual meeting of The New Orleans Graduate Medical Assembly will be held February 27, 28, 29 and March 1, headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, color television, medical motion pictures, round-table luncheons and technical exhibits.

Details of the New Orleans meeting and post-clinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

**SEMINAR IN OPHTHALMOLOGY AND
OTOLARYNGOLOGY**

The Tenth Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of January 16, 1956. The lectures on Ophthalmology will be presented on January 16, 17 and 18, and those on Otolaryngology on January 19, 20 and 21. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 18, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p. m. on Wednesday. The schedule has been changed to provide a maximum time for recreation each afternoon.

**CITIZENS COMMITTEE FOR THE
HOOVER REPORT**

"Twenty-four executive officials will have the key responsibility for carrying out the 314 recommendations of the Hoover Commission," Clarence Francis, National Chairman of the Citizens Committee for the Hoover Report, stated recently.

"Some of them have responsibility for a large number of the recommendations, and others only a few," said Mr. Francis, who is also retired Board Chairman of General Foods Corporation. "For example, 85 proposals will have to be acted on by the Secretary of Defense. The Budget Director has primary responsibility for 52; the President himself, for 28.

"An analysis by the research staff of the Citizens Committee," Mr. Francis added, "shows that roughly 45 per cent of the proposals require legislation; 46 per cent can be acted upon administratively, and for 9 per cent further study will be required. Hence, the roles of these officials will differ from recommendation to recommendation. Of the 52 on which the Budget Bureau can take action, 21 require passage of legislation by the Congress, 25 need administrative action, and 6 involve further study.

"The 85 recommendations for which the Secretary of Defense has some responsibility could lead to large savings—particularly in the cases of the Commission's reports on Transportation and Subsistence. Those two task forces estimated possible annual savings of \$551 million. Much of this money can be saved by the Department of Defense administratively—that is, without Congress passing any legislation at all. The 85 recommendations affecting the Defense Department also involve modernized management of the military establishment's supply system and the elimination of over 1,000 activities which unnecessarily compete with private enterprise. An energetic program of implementation in the Defense Department is already well under way."

The Citizens Committee's Special Research Memorandum No. 5, entitled "Officials Responsible for Implementing the Hoover Commission's Recommendations" is available upon request at the Citizens Committee for the Hoover Report, 777—14th Street, N. W., Washington 5, D. C.

INTERNATIONAL CONGRESS ON DISEASES OF THE CHEST

The Fourth International Congress on Diseases of the Chest, sponsored by the Council on International Affairs of the American College of Chest Physicians, will be held in Cologne, Germany, August 19 through 23, 1956.

The scientific program to be presented at the Congress is now being organized and physicians having carried out original work in diseases of the chest (heart and lungs) which they wish to present, are invited to send outlines of their studies to

Dr. Andrew L. Banyai, Chairman, Committee on Scientific Program, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

The Hon. Ernst Schering, Mayor of Cologne, extends a cordial invitation to physicians and surgeons throughout the world to attend this congress on chest diseases. Write: Executive Offices, American College of Chest Physicians, 112 East Chest Street, Chicago 11.

FROM: AMA COMMITTEE TO REVIEW THE FUNCTIONS OF THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

In June, 1955, the House of Delegates of the American Medical Association authorized the Speaker to appoint a committee "... to review the functions of the Joint Commission on Accreditation of Hospitals ..." and "... to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on Accreditation of Hospitals."

This Committee was appointed, and now, in undertaking the task assigned to it, is seeking to obtain from physicians and others their observations concerning the functioning of the Joint Commission.

It is obviously impossible for the Committee to contact all physicians and others who may have observations or comments concerning the matter of hospital accreditation. You, however, could be of invaluable assistance to the Committee by notifying your membership of the existence of the Committee and its survey. The Committee therefore would appreciate it if you would reproduce this memorandum in your journal, bulletin, newsletter, or in some special mailing to your membership. This would assist the Committee to obtain a cross section of observations concerning the accreditation program.

The Committee is interested especially in the following:

1. The general understanding by physicians of the functions of the Joint Commission.
2. Whether the method of appeal from an adverse ruling regarding accreditation is satisfactory.
3. The effect on the individual physician's hospital connections due to actions of the Joint Commission.
4. Whether any organizations not now represented should have official representation on the Joint Commission.
5. The effect of the Joint Commission's requirements concerning such matters as staff meetings.

6. The pros and cons of separating administrative and professional accreditation functions in the inspection of hospitals.
7. Constructive suggestions for improving the hospital accreditation program.

Any comments from individual members or state and county societies should be addressed to:

W. C. Stover, M.D., Chairman
Committee to Review Functions of
Joint Commission on Accreditation of Hospitals
535 North Dearborn Street
Chicago 10, Illinois.

These comments should reach the chairman not later than January 15, 1956.

LETTERS

STATE OF ARKANSAS

DEPARTMENT OF PUBLIC WELFARE

Little Rock

Nov. 1, 1955

Mr. Paul Schaefer, Secretary
Arkansas State Medical Society
Fort Smith, Arkansas

Dear Mr. Schaefer:

Some three weeks ago doctors in Little Rock were being circularized with a letter of solicitation of fund to which was attached a metal insignia (MD) by an organization known as "Eyes Right, Inc."

It was found not listed as an accredited organization in the Givers' Guide in New York City. It was also found that the raising of funds by sending unsolicited merchandise is considered unethical by the National Information Bureau, as well as the Better Business Bureau.

This organization has been in existence for about two years, and has not raised more than expense money. It has not done any research or prevention work such as they describe in the literature.

It is suggested that this organization be brought to the attention of Arkansas physicians.

K. W. Cosgrove

A recent poll of a national cross-section of physicians states that "90 per cent are still sharing bed and board with their original mates." And just 6 per cent have been divorced (compared with a national divorce rate of almost 20 per cent).—October Medical Economics.

Obituary

CHARLES DAVID TIBBELS, 76, well known Black Rock physician, was found dead at the bottom of a 20 foot well on the back porch of his home October 22.

Dr. Tibbels was one of the best known physicians in Arkansas. He was a graduate of the University of Tennessee Medical School and had practiced medicine in Black Rock since the early 1900's.

Dr. Tibbels was born in Sharp County. He was a minister in the Baptist Church.

He is survived by his wife, three daughters, three sons, a step-daughter, two sisters, two brothers, 12 grandchildren, and five great grandchildren.

Funeral services were held in Black Rock.

RILEY COWAN met death instantly October 8, when his car crashed into a truck. He was 79 years old and had resided in Van Buren for the last 12 years.

He was a 32nd degree Mason, member of the Royal Arch, Van Buren Rotary Club, Southern Drug Association, American Medical Association, Arkansas Medical Society, and Crawford County Medical Society of which he had served as president and secretary. He was the local surgeon for the Missouri Pacific Railroad and at one time was the county health officer.

A Masonic graveside service was conducted preceding the burial in Forest Park Cemetery.

Surviving relatives are his wife, Mrs. Edith Belle Cowan, and two daughters.

JOHN F. BREWER, 80, North Little Rock, a native of Lonoke County, died October 19 in a Little Rock hospital.

Dr. Brewer was a practicing physician 44 years and was surgeon for the Rock Island Lines for more than 30 years, retiring in 1945. He began his medical career in Kerr (Lonoke County) after graduating from Memphis Hospital Medical College in 1901.

The University of Tennessee had just presented Dr. Brewer with a Golden "T" for faithful practice in the medical profession. He taught school in Lonoke and Cleveland counties prior to entering medical school.

A charter member and a past president of the Lonoke Medical Society, he was also an honorary member of the Arkansas Medical Society and a member of the Surgical Association of the Rock Island Lines.

Dr. Brewer was a Methodist, a Mason and a member of the Woodmen of the World and the North Little Rock Elks Lodge.

Surviving are his widow, two sons, a daughter, two step-daughters, eight step-grandchildren, and two great-grandchildren.

Funeral services were conducted by the Rev. Aubrey G. Walton in Little Rock.

S. A. COLLUM, Texarkana, Texas, died October 10 of a self-inflicted wound.

He was a graduate of Texas University and of Vanderbilt Medical School and had practiced in Texarkana since 1930.

A past-president of the Texarkana Rotary Club, Dr. Collum was active in civic and public affairs, in his state medical society and in the Southern Medical Association.

He is survived by Mrs. Collum, the former Mary Maddox, and two daughters.

Interment was in Hillcrest Cemetery.

ARLES A. BLAIR, widely-known specialist in internal medicine and cardiology, died October 25 in a Fort Smith hospital at the age of 64.

Funeral service was held at the First Methodist Church, and burial at the Forest Park Cemetery.

Born in Scranton, Ark., Dr. Blair had lived in Fort Smith ever since he was discharged from the army as a captain in the medical corps at the end of World War I.

Active in the First Methodist Church, the doctor was a trustee of that church and a past chairman of the board of stewards.

He was a graduate of the University of Tennessee Medical School, was on the staffs of St. Edwards, Sparks and Crawford County Hospitals. He served as chief of staff at St. Edwards at one time.

He was ex-governor of the state for the American College of Physicians, a past president and member of the advisory board of the Sebastian County Medical Society and a member of the American Heart Association.

Widely-known in medical circles, Dr. Blair was an associate clinical professor of medicine at the

University of Arkansas, Fayetteville, and a consultant in internal medicine at the Veterans Hospital, Fayetteville, and the post hospital at Camp Chaffee.

Although extremely busy in his church work and medical profession, Dr. Blair found time to serve as president of the Sebastian County TB Association from 1947 to 1953 and on the school board from 1935 to 1946.

Dr. Blair also was the author of several scientific articles on heart diseases and related subjects.

Survivors include his wife, Mrs. Florence Blair, two daughters, three sisters, and four grandchildren.

ERNEST RAS BROWNING, 74, past president of the Garland County Medical Society and a physician here since 1917, died October 4 at his home, 202 Sixth Street.

A native of Mississippi, Dr. Browning came to Arkansas at the age of nine.

He was graduated from Mt. Ida High School and from the University of Arkansas Medical School in 1913. He practiced at Buckville prior to coming to Hot Springs.

Dr. Browning was a member of the American Medical Association and of the Arkansas Medical Society.

He leaves his wife, Mrs. Lena Browning of Hot Springs, one sister, and two brothers.

Burial was in Greenwood Cemetery.

BUY

U. S. SAVINGS

BONDS

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

REPRODUCED FOR ARKANSAS PHYSICIANS BY THE ARKANSAS TUBERCULOSIS ASSOCIATION

"A CHRISTMAS SEAL SERVICE"

PULMONARY COIN LESION

JOHN F. HIGGINSON, M.D., and DAVID B. HINSHAW, M.D.,

Journal of the American Medical Association, April 30, 1955

The problem of the asymptomatic solitary, coin-shaped, pulmonary lesion was first fully presented in 1948, by O'Brien and others, who studied 21 patients in whom coin-shaped pulmonary roentgenographic shadows were seen on routine or survey chest roentgenograms. In all instances an exact diagnosis was impossible by clinical methods. The possibly serious nature of the lesions indicated an exploratory thoracotomy in order to establish a histological diagnosis. Eight, or 38 per cent, of the 21 patients had bronchogenic carcinoma, and the others had tuberculomas or other nonmalignant lesions. The conclusion of this study was that all such solitary, benign-appearing, pulmonary lesions should be treated by exploratory thoracotomy rather than prolonged observation. Similar studies by other investigators show considerable differences in the selection of cases and in the types of lesions found at surgery. The percentage of malignant tumors (including bronchogenic carcinoma lymphoma, metastatic carcinoma, and various types of sarcoma) that have been found has varied from 15 to 55 per cent. The percentage of bronchogenic carcinoma only has ranged from 4.6 to 49 per cent. The other common entities found have been tuberculomas and hamartomas.

Different authors have used varied criteria for selecting patients; however, all have agreed that the pulmonary shadows in question must be solitary, essentially asymptomatic, and reasonably circumscribed. It has also been agreed that the lesions must be in the lung parenchyma and must be inaccessible to biopsy except by exploratory thoracotomy. There are differing opinions on the inclusion of cavitating lesions and calcific lesions. However, the lack of agreement regarding the size of the lesion has been most apparent. Some authors have specified that the roentgenographic shadows found in their patients should not exceed 4 cm. but it is apparent from the published roentgenograms that many much greater in diameter

have been included. The term "coin" implies definitely small, solitary lesions. In view of the differences in criteria of selection, different reports on the incidence of solitary pulmonary shadows, subsequently proved to be malignant tumors, are not surprising.

It is our purpose to emphasize the problem of the small, solitary, pulmonary lesion commonly referred to as a "coin lesion" with regard to case selection and to present a study in the evaluation of the many benign-appearing pulmonary lesions of this type being found in chest surveys. This has seemed especially important because of the common and persistent connotation of benignancy associated with the use of the term "coin lesion."

The patients in this study were all seen by the thoracic surgeon after a solitary, isolated, round or oval (coin-shaped), asymptomatic pulmonary shadow was found either on a routine chest roentgenogram or on a chest survey roentgenogram for tuberculosis. Exploratory thoracotomy was performed in each case. The following criteria for selecting the cases were carefully observed. 1. Only a solitary lesion was noted on the roentgenogram of the chest. 2. There was no evidence of attachment of the lesion to the chest wall. 3. The lesion was located in the lung parenchyma and was surrounded by aerated lung tissue. 4. There was no cavitation. Cavitation in any unidentified pulmonary lesion is simply another indication for surgical exploration. 5. The lesion was well circumscribed. 6. No adjacent pulmonary infiltration was noted. 7. No lesion was more than 4 cm. in diameter. If larger lesions were included, the series would be much greater; however, larger lesions are automatically considered to demand exploration. Difficulties and dangers arise in the procrastination that occurs with smaller, or coin-sized lesions. The 4 cm. limitation proposed earlier agreed with our experience. 8. There were no symptoms that in themselves encouraged surgical exploration. 9. It was not pos-

sible to establish a histological diagnosis by bronchoscopy or by other means.

It is not feasible to give a detailed presentation of all 39 cases included in this study. In all instances the patients had many sputum studies, including cultures for *Mycobacterium tuberculosis*, tuberculin and coccidioidin skin tests, multiple chest roentgenograms, and bronchoscopy. The preoperative diagnosis in all cases was pulmonary coin lesion of an undetermined nature. There was no surgical mortality, and the surgical morbidity was low. Twenty-eight were in the Veterans Administration Hospital, Portland, Oregon, and 11 were private patients.

The incidence of bronchogenic carcinoma in this series was 10.3 per cent, which is higher than the 4.6 per cent recorded in another study. The latter series, however, was drawn largely from a relatively young age group. It would seem that the older the patients, the higher the incidence of bronchogenic carcinoma.

One case of solitary melanoma of the lung was included in this series; no extrapulmonary primary source of this was found. With the inclusion of this case, the cases of patients with alveolar cell carcinoma and bronchogenic carcinoma, the incidence of malignant coin lesions becomes 15.3 per cent of the total. It appears that the frequency of bronchogenic carcinoma in small circumscribed, pulmonary (coin) lesions is nearer to 10.3 per cent than to some of the much higher percentages that have been reported. The high incidence of coccidioidal granulomas probably reflects the fact that many of the patients have lived near areas where this disease is endemic.

The wisdom of surgical exploration and histological identification of these solitary, benign-appearing, coin lesions is evident. The possibility of primary bronchogenic carcinoma being present is sufficient justification for exploration. Until recently physicians usually observed these patients with a presumptive clinical diagnosis of tuberculoma or benign neoplasm for a long time and, unfortunately, some physicians still do. The danger of this is obvious. The roentgenographic appearance of the lesion or any combination of clinical and laboratory tests will not show what the histological nature or bacteriological threat may be in an individual patient. A coin lesion in the lung should be considered as one considers a small lump in the breast, i. e., as malignant until proved otherwise.

It is generally accepted that the proper treatment for a known tuberculoma is removal by sur-

gery. It has been shown that many so-called tuberculomas contain viable tubercle bacilli. These tuberculomas can and do caseate, cavitate, and produce widespread pulmonary disease. Some authorities believe that approximately 25 per cent of the untreated tuberculomas "break down." Of the lesions in this study, 31 per cent proved to be tuberculomas. We believe that the presence of calcium in a coin lesion should not defer surgical exploration unless the patient is a poor surgical candidate with systemic disease or unless the lesion is less than 1.5 cm. in diameter and is solidly calcified. After the surgeon is satisfied as to the histopathological diagnosis, he may then perform whatever definitive surgical treatment is indicated. In view of the many chest roentgenogram surveys that are being conducted throughout the United States, it is important that all physicians be made aware of this problem in order that they may properly advise the patients referred to them from the survey centers.

Results in a series of 39 cases of solitary, parenchymal, so-called pulmonary coin lesions show that a significant number of these lesions are malignant neoplasms or tuberculomas and should, for this reason alone, be treated by exploratory thoracotomy and identification rather than by a period of observation. Prompt surgical attack on the so-called pulmonary coin lesion affords one of the best opportunities for early discovery and early treatment of bronchogenic carcinoma.

PERSONALS AND NEWS ITEMS

Sam G. Jameson, El Dorado, presented a film, "Thoraco-Abdominal Mephrectomy" at the South Central Section of the American Urological Association in San Antonio October 19. The movie is also slated for a meeting of the Southeast Section of the same body to meet in Miami in April 1956. It was made at Warner-Brown Hospital in El Dorado with the technical assistance of David M. Yocum, a staff member.

At this same meeting Dr. Jameson was awarded a plaque honoring the physician presenting the most outstanding problem case to the society. He also wishes readers of the **Journal** to know that the films are available to our county medical societies for the asking (16mm. Kodachrome, silent). The **Journal** congratulates our fellow member.

The Southeast Arkansas Medical Society met in Monticello for their October program, which was given by T. E. Townsend and Calvin Simmons of Pine Bluff.

"Fox Hunter of the Year" is the latest title awarded Joe F. Shuffield, Little Rock, and it was conferred by a physician-friend, T. E. Rhine of Thornton, last October. The event was held in Heber Springs. Shuffield was reappointed to the Fish and Game Commission in 1951 for a seven-year term.

Jim Bethel, a graduate of the University of Arkansas School of Medicine, has joined the Pig-gott Hospital Staff and has opened his offices in the city for general practice.

Joe E. Hutchinson, Gravette, has purchased the Wilson Clinic from Wilford Wilson, who retired from active practice November 1.

John A. Rowland, formerly business manager for Trinity Hospital and Clinic, has returned to Little Rock as Executive Director of the Arkansas Blue Cross-Blue Shield Plan.

J. Harry Hayes, Little Rock, attended the National Meeting of the International College of Surgeons in Philadelphia, September 12th, 13th and 14th.

L. Murphey Henry, Fort Smith, is a recent Diplomate of the American Board of Ophthalmology.

President L. H. McDaniel gave the Dinner Address at the dedication of the State Medical Society of Wisconsin building on October 15.

Robert E. Wyers, Class of '27, University of Arkansas School of Medicine, Superintendent and Medical Director of the Metropolitan State Hospital, Norwalk, California, was given an award by the American Psychiatric Association for making the most outstanding improvement in a mental hospital in the past three years. The award was presented to Dr. Wyers at the annual meeting of the Hospital Administrators Institute, Washington, D. C., October 3, 1955. The award is given annually by the American Psychiatric Association to stimulate improvement for care and treatment of mental patients.

Dr. and Mrs. Wyers (nee: Crystal White) visited friends in Arkansas on their return trip to California.

Don Mashburn, Lonoke, opened an office in the Cleveland County Memorial Hospital in Rison, in October. He will do a general practice.

PROCEEDINGS OF SOCIETIES

Note: Secretaries of County and District Societies are invited to use this column to announce coming meetings as well as to report these meetings. Such meetings, announced in advance, will be more apt to draw visiting physicians from surrounding areas.

Craighead-Poinsett Medical Society met November 2 at Noble Hotel, Jonesboro. Program: "Extra Uterine Pregnancy," Ralph Betheza, Memphis, instructor in Obstetrics and Gynecology. A film on "Toxemia of Pregnancy." Plans were made for the Annual Barbecue for December 7.
J. H. McCurry, Cash,
Secretary.

The First Councilor District Medical Society met at the Hotel Noble in Blytheville on Thursday, October 7, 1955. The Welcome Address was given by R. L. Johnson, Blytheville, President of the Mississippi County Medical Society, with a response by Eldon Fairley, Wilson, President of the First Councilor District Society.

"Fluids and Electrolytes in Children" was discussed by C. H. Snyder of New Orleans and Roder Bost of Fort Smith.

"Urological Problems in Children" was the title of a paper by George Beckman of New Orleans. Curry Bradburn of Little Rock discussed the paper. The program was arranged by J. E. Beasley and F. E. Utley of Blytheville.

The Mississippi County Auxiliary entertained the visiting ladies in the afternoon.

J. H. McCurry, Sec.

The Ouachita County Medical Society was entertained with a steak dinner at the Camden Hotel, November 3, by John H. Miller of Camden. Following the dinner Dr. Miller gave an illustrated travel talk about his recent two months visit to Europe, the Middle East and Africa.

The Arkansas County Medical Society and Auxiliary held a joint dinner meeting in DeWitt October 20. Lucille Champion, President, presented two films, "The Peptic Ulcer," and "Modern Nutrition," which were shown and discussed.

At its business meeting, presided over by the auxiliary's president, Mrs. E. A. McCracken, the auxiliary voted to send the magazine, "Today's Health," to the libraries of the DeWitt, St. Charles, Gillett, Immanuel, Holman, and Stuttgart high schools.

The Arkansas Obstetrical-Gynecological Society held a two-day convention with a buffet luncheon, followed by attendance at the U. of A. vs. Texas U. football game.

The sessions were devoted to technical papers, films and slides, as well as round-table discussions.

The speakers included Deane Wallace, A. T. Gillispie, and Hoyt Choate, Little Rock physicians; Kermit Krantz, Willis Brown, Joe Presley, and James Atkinson, University of Arkansas School of Medicine; B. H. Passmore, San Antonio, Texas, and Raymond Schwegler, University of Kansas School of Medicine.

The Ouachita County Medical Society was entertained by R. B. Robins, December 8, with a turkey dinner at the Camden Country Club. Dr. Robins has been secretary of this society for over a quarter of a century (27 years). The guest speakers were Euclid Smith, Hot Springs, L. H. McDaniel, Tyrone, and William Strauss, Philadelphia.

The fall meeting of the Third Councilor District Medical Society met in Helena on Thursday, October 27. A social hour followed the program which closed with election of officers.

Out of town speakers were: C. D. Hawkes, Gwin S. Robbins, Pervis Milnor, all of Memphis, and R. L. Foreman, of Clarksdale, Mississippi.

The Arkansas Radiological Society met September 2, 1955, in Little Rock.

President Burton discussed his meetings with the Arkansas Rehabilitation Committee, stating that no definite fee schedule for X-ray examinations had yet been decided. It was the consensus of the group that he be allowed, in the name of the Society, to vary from the fee schedule adopted March 11, 1955, by as much as 50 per cent, if necessary.

There was a general discussion concerning the speaker to be obtained for the Radiology Section at the State Medical meeting in 1956.

Dr. Barnhard then gave information concerning the University Radiology Department, announcing a new film-reading session to be held the second Monday of each month, starting at 7:15 p. m. These sessions will be at the University Radiology Department.

A resolution presented to the Fifth Medical District of Arkansas for the creation of a committee for the purpose of assisting in the dispo-

sition of estates of deceased or permanently or totally disabled, etc., doctors of medicine.

1. Committee to be appointed or designated by the president of the District and is to be composed of all county medical society presidents. The chairmanship would be the one in whose county the doctor resides. It is to be a perpetual committee.

2. The committee would (after obtaining consent from the estate) assist in the disposition of the "medical affairs" of the deceased. This is to include:

A. Secure an inventory of all office supplies, books, etc. Have same appraised at a reasonable marketable value and present same at the next district meeting for disposition.

B. Accounts receivable to be collected through the name of the committee at the earliest time possible and such proceeds to be given to the estate with proper records, etc.

C. Any real estate, such as office building, the committee may act, or consult advisors, etc., if desired.

3. No charges can be levied by members of the committee for their service.

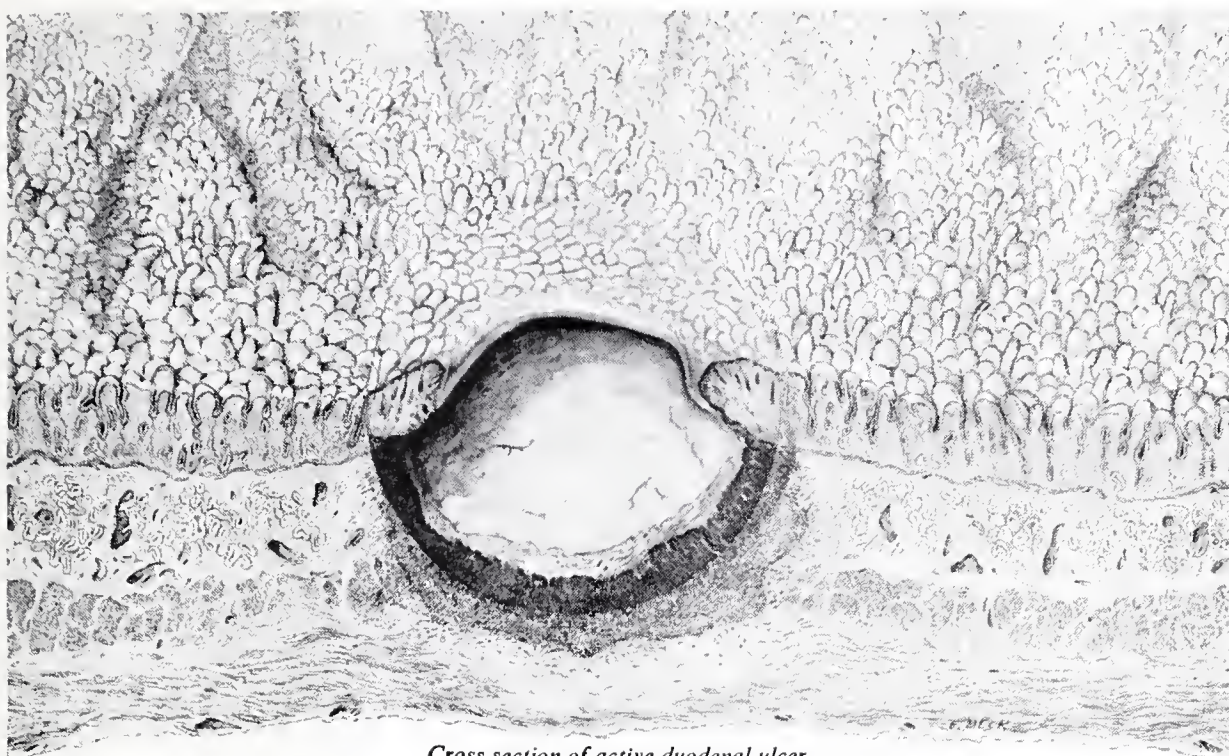
4. Any relative of a deceased member of the county society is entitled to the services of the committee in liquidating the estate of the deceased member; also the members of the committee may use their discretion in liquidating the estate of an inactive or former member of the county society.

5. Power of attorney or proper legal authority must be first obtained from those interested in the estate of the deceased member of the society before rendering any service whatsoever.

Resolution adopted.

Paul G. Henley, Sec.
El Dorado





Cross section of active duodenal ulcer.

Dramatic Remission of Ulcer Pain

Pain of ulcer is associated with hypermotility; the pain is relieved when abnormal motility is controlled by Pro-Banthine.

"In studying¹ the mechanism of ulcer pain, it is obvious that there are at least two factors which must be considered: namely, hydrochloric acid and motility.

"... our studies indicate that ulcer pain in the uncomplicated case is invariably associated with abnormal motility....

"Prompt relief of ulcer pain by ganglionic blocking agents... coincided exactly with cessation of abnormal motility and relaxation of the stomach."

Pro-Banthine Bromide (β -diisopropylamino-ethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is a new, improved, well tolerated anticholinergic agent which consistently reduces hypermotility of the stomach and intestinal tract. In peptic ulcer therapy² Pro-Banthine has brought about dramatic remissions, based on roentgenologic evidence. Concurrently there is a reduction of pain, or in many instances, the pain and discomfort disappear early in the program of therapy.

One of the typical cases cited by the authors² is that of a male patient who refused surgery despite the presence of a huge crater in the duodenal bulb.

"This ulcer crater was unusually large, yet on 30 mg. doses of Pro-Banthine [q.i.d.] his symptoms were relieved in 48 hours and a most dramatic diminution in the size of the crater was evident within 12 days."

Pro-Banthine is proving equally effective in the relief of hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm. G. D. Searle & Co., Research in the Service of Medicine.

1. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, *Gastroenterology* 23:252 (Feb.) 1953.

2. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, *Gastroenterology* 25:416 (Nov.) 1953.



MRS. LOUIS K. HUNDLEY

The Journal salutes Mrs. Jean (Louis K.) Hundley who has just finished a banner year as President of the Auxiliary of the Southern Medical Association. Mrs. Hundley is an indefatigable worker in medical auxiliary having been president of her county group and of the Auxiliary to the Arkansas Medical Society.

Her immediate avocation, after homemaking for husband, Louis K. Hundley and their nearly-grown children, is work with the National Foundation of Infantile Paralysis, where she has been the

Arkansas Advisor for more than five years. She was cited by the Arkansas Academy of General Practice in 1954 for unusual accomplishment in health activities and in public relations.

She is active in the Methodist Church and in the Pine Bluff Junior Auxiliary. Her most recent honor came when she was given an Arkansas Traveler Certificate by Governor Faubus, for outstanding work with the Polio Foundation and with handicapped children.

Our hat is off to Jean Hundley!

WOMAN'S AUXILIARY

As president of the Woman's Auxiliary to the American Medical Association, Mrs. Mason G. Lawson of Little Rock attended the meeting of the Southern Medical Association in Houston November 14-17 and the American Medical Association Regional Legislative Conference in Dallas on November 19.

Mrs. Lawson was in Boston November 27-December 2 for the Interim meeting of the American Medical Association.

On December 6 and 7, she attended a Committee meeting to plan the President's Conference on Children and Youth in Washington.

Following the dinner served to the Craighead-Poinsett Medical Society and Auxiliary on October 5 at the Hotel Noble in Jonesboro, the Auxiliary met for its monthly business session and program with the president, Mrs. G. J. Forestiere of Harrisburg, presiding. "The County Farm—making its inhabitants feel wanted," is again the project for the coming year with Mrs. E. J. Stroud as Project Chairman. Mrs. Joe Verser of Harrisburg gave an informative talk on the Bricker Amendment, the Re-insurance Bill, and the Jenkins-Keogh Bill after which all present participated in a round-table discussion.

Pulaski Auxiliary Begins Year

(Clipped from the Arkansas Democrat)

The Woman's Auxiliary to the Pulaski County Medical Society will open its fall season Wednesday at the YWCA. A coffee will be held from 10:30 to 11:30 a. m., preceding the business session, to enable the regular group to meet the new members.

The program includes a film emphasizing the need of medical schools and how they are met through contributions to the American Medical Education Foundation.

Guests will include Mrs. John T. Gray of Jonesboro, president of the state auxiliary; Dr. Edwin Gray, president of the Pulaski County Medical Society, and Dr. Charles R. Henry, advisor to the auxiliary from the society.

Mrs. Erner Jones, auxiliary president, is assisted by Mrs. William Snodgrass, president-elect; Mrs. Edwin Gray and Mrs. Ray Fulmer, vice presidents; Mrs. Kenneth Jones, recording secretary; Mrs. Guy Farris, treasurer; Mrs. Joseph Buchman, cor-

responding secretary; Mrs. J. R. Warden, historian; Mrs. Curtis Jones, Sr., parliamentarian; Mrs. T. J. Raney, Jr., publicity secretary, and Dr. Henry as advisor.

Committee chairmen include: Program, Mrs. Snodgrass; hostesses, Mrs. Ray Fulmer; memorial and chaplain, Mrs. T. D. Brown; membership and visiting, Mrs. George Regnier and Mrs. John Hundley; telephone, Mrs. Joseph Calhoun and Mrs. Harold R. Hipp; medical legislation, Mrs. William Cooper; budget and finance, Mrs. Charles R. Henry; civil defense, Mrs. Robert Watson; library fund, Mrs. Fred Gray, Jr.; revisions, Mrs. Gordon Oates; student nurse friend, Mrs. James Newbill; loans, Mrs. Harry Hayes; public relations, Mrs. Thurston Black; medical student wives, Mrs. Calvin Dillaha and Mrs. John Baber; medical assistants, Mrs. Joe B. Scruggs; city federation, Mrs. Ben Means and Mrs. Gilbert Dean; bulletin and today's health, Mrs. John Christian; nurse recruitment, Mrs. Eugene Crawley; mental health, Mrs. Hoyt Choate; rural health, Mrs. Verdo T. Webb, and doctor's day, Mrs. Dale Alford.



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 Drennen, S. A. Stuttgart, Wabash 2-3531
 John, Milton C., Jr. Stuttgart, Wabash 2-1492
 McCracken, E. A. Stuttgart, Wabash 2-1372
 Rasco, C. W., Jr. DeWitt, Whitney 6-3156
 Riley, H. C. Bayou Meto, Wilson 9-4164
 Stone, Fred B. Stuttgart, Wabash 2-1492
 Van Duyn, T. S. Stuttgart, Wabash 2-5112
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 Whitehead, R. H., Sr. DeWitt, Whitney 6-4181
 Wilson, J. G. Keo, Victoria 2-3115
 Young, Philip M. % Richards Clinic, Rockdale, Tex., Hillcrest 6-5854

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 Swigart, L. Lake Crossett, Forest 4-4114
 *White, E. O. Hamburg
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 Black, T. N. 236 Central, Hot Springs, National 3-5121
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 Kelly, Robert M. Sheridan, Whitehall 2-1501
 *Kelly, Obie R. Sheridan

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Griffin, John S. 619 Main, Texarkana, 3-5173
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 Bost, Roger B.222-A South 16th, Fort Smith, Sunset 3-1486
 Boulden, Cecil F., Jr.100 South 14th, Fort Smith, Sunset 3-1183
 Brooksher, W. R.100 North 16th, Fort Smith, Sunset 3-4803
 Chamberlain, Charles T.1500 Dodson, Fort Smith, Sunset 2-4092
 Clarke, A. S. J.U. S. Army
 Crigler, Ralph E.1500 Dodson, Fort Smith, Sunset 2-4092
 Darnall, Harley C.700 South 26th, Fort Smith, Sunset 2-4850
 Dorsey, H. C.P. O. Box 330, Fort Smith, Sunset 3-1733
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 Faier, S. Z.1500 Dodson, Fort Smith, Sunset 2-4092
 Foltz, T. P.1600 Rogers, Fort Smith, Sunset 2-4051
 Foster, M. E.100 South 14th, Fort Smith, Sunset 3-1183
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 Knight, W. E.1500 Dodson, Fort Smith, Sunset 2-4092
 Koenig, A. S.602 Garrison, Fort Smith, Sunset 3-6720
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 Martin, Art B.1500 Dodson, Fort Smith, Sunset 2-4092
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 Moulton, E. C., Jr.1214 North "B", Fort Smith, Sunset 2-6019
 Olson, John D.1500 Dodson, Fort Smith, Sunset 2-4092
 Post, James M., Jr.305 South 16th, Fort Smith, Sunset 2-8435
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Clark, J. F. 425 West Oak, El Dorado, Union 3-4267
Clowney, A. R. 312 North Jefferson, El Dorado, Union 3-4101
Cooper, James O. 114 West Oak, El Dorado, Union 3-6036
Cullins, John G. Veterans Hospital, Wadsworth, Kansas
Cyphers, Charles D. 506 West Faulkner, El Dorado, Union 2-3471
Doren, Austin H. Smackover
Duzan, Kenneth R. 114 West Oak, El Dorado, Union 2-3677
Ellis, Jacob P. 403 South West Avenue, El Dorado, Union 3-7163
Fincher, L. G. 328 West Oak, El Dorado, Union 3-4175
Fincher, L. G., Jr. 328 West Oak, El Dorado, Union 3-4175
Fitch, L. E. 209 Murphy Bldg., El Dorado, Union 3-7217
Handley, W. H., Jr. 426 No. Washington, El Dorado, Union 3-3411
Harper, John W. Harper Clinic, El Dorado, Union 3-5135
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Irby, F. L. 316 Schuler Bldg., El Dorado, Union 3-7600
Jameson, Sam 412 North Washington, El Dorado, Union 2-3411
Kennedy, Charles E. Smackover
Landers, Gardner H. 506 West Faulkner, El Dorado, Union 2-3471
McCall, Daniel H. Lawton
McKinney, J. S. 428 North Washington, El Dorado, Union 2-3415
Mayfield, H. J. 114 West Oak, El Dorado, Union 3-7430
Mayfield, Hugh F. Huttig
Moore, Berry L. 218 Masonic Temple, El Dorado, Union 3-4185
Munn, E. J. 314 Armstrong Bldg., El Dorado, Union 3-5731
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Murphy, G. D., Sr. 304 East Peach, El Dorado, Union 3-7128
Murphy, H. A. 403 West Oak, El Dorado, Union 3-3866
Murphy, Randolph 306 Schuler Bldg., El Dorado, Union 3-7768
Newton, W. L. Smackover
Pinson, J. H., Jr. 312 North Jefferson, El Dorado, Union 3-4101
Pollard, Ted Junction City
Price, Troy M. Strong
Rainwater, W. S. 1104 North Magnolia, El Dorado, Union 3-5135
Riley, Warren S. 302 Schuler Bldg., El Dorado, Union 3-4508
Sheppard, Jack M. Schuler Bldg., El Dorado, Union 3-7154
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Slaughter, James W. Box 828, El Dorado, Union 3-8493
Thibault, Frank G. 430 South West Ave., El Dorado, Union 3-7163
Tommey, C. E. 1806 Laurie, El Dorado, Union 2-3411
Turnbow, R. L. 209 Murphy Bldg., El Dorado, Union 2-3971
Wharton, J. B., Sr. 312 North Jefferson, El Dorado, Union 3-4101
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White, D. E. 207 Armstrong Bldg., El Dorado, Union 3-3712
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Applegate, Stanley Springdale Clin., Springdale, Pleasant 1-4637
Baggett, Jeff Prairie Grove, Vinewood 6-2321
Bloom, Charles F. Westfork, 21F2
Boyer, H. L. Lincoln, 4-1701
Brizzolara, Charles M. 5512 South Grandview Road
Little Rock, MO 6-5977

Brown, Spencer H. 106 1/2 W. Center, Fayetteville, Hillcrest 2-7309
Butler, G. Harrison 316 W. Dickson, Fayetteville, Hillcrest 2-8217
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Huntington, R. H. Box 62, Fayetteville, Hillcrest 2-5141
Kaylor, Coy C. 212 North College, Fayetteville, Hillcrest 2-4482
Leming, Howell E. 114 East Spring, Fayetteville, Hillcrest 2-7291
Lesh, Ruth Ellis 221 North College, Fayetteville, Hillcrest 2-5112
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McAllister, Max 18 East Dickson, Fayetteville, Hillcrest 2-4011
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Riggall, Cecil VA Hospital, Spokane, Washington, Empire 1650
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The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

January, 1956

No. 8

GYNECOLOGIC SURGERY IN THE GERIATRIC PATIENT*

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The term "gynecologic surgery" is a rather loose one that might encompass almost any operation on a female but is perhaps most appropriately applied to pelvic or vaginal operations. The term "geriatrics" is utilized to describe the process of aging or the study of old age and its diseases. In order to have a more definite program to discuss, I have arbitrarily taken the chronologic ages 61 and over to represent geriatric patients. Even with this limitation we are dealing with a large number of people, for the average life expectancy for adult women is now more than 70 years. As these women become older, they are subject not only to tumorous growths but to all the stresses and strains of advancing years, and one of the most troublesome regions is the birth canal.

All conditions in which surgery plays a part in the care of the gynecologic geriatric patient should be considered. These may be divided roughly into four major categories: (1) acute conditions, which constitute emergencies or semi-emergencies and which must be treated as they would be treated in a patient of any age, (2) chronic lesions that have developed over a period of years, such as descensus of the uterus, cystocele, rectocele or incontinence, (3) benign tumors that present a problem as to their treatment yet do not seem to offer an immediate threat to the patient's life and (4) the rather large group of malignant lesions of the genital tract that are encountered in any group of older women.

Basic Considerations

First, there are a number of basic considerations that should be discussed in their relationship to surgery. In geriatric patients, probably more than in any others, one must consider the entire problem that the patient presents. The older patient more often than not has infirmities over and

above the specific surgical lesion. When these infirmities are cardiac, renal or perhaps diabetic, they must be given careful thought, and treatment must be instituted to counteract the trouble and reduce the risk of the surgical procedure. This may well mean a few days in the hospital to digitalize the patient or to be certain that her diabetes is under satisfactory control.

Hypertension.—Hypertension is common but it should be adequately evaluated both as to duration and as to the effects it has had on the patient's body. The cardiac reserve is important, and it is well to ask an older patient what she can do comfortably. Can she walk around and shop and carry some groceries? Can she go up a flight of stairs without pausing and without pain? Does she take care of a small flower garden or vegetable plot? Does she take any regular exercise such as playing golf? Is she energetic and does she enjoy physical activities? Such questions may elicit the information that is most helpful in deciding whether the cardiovascular system is able to undergo the stress of a surgical procedure.

Weight.—Loss of weight should be investigated. A patient may lose weight because of an extensive malignant process, but she can lose it just as readily because of worry, unhappy surroundings or insufficient rest. Poorly fitting dentures and inability to chew comfortably often cause her to take a very inadequate diet with resultant loss of body tissues and especially loss of protein. On the other hand, if the patient is obese and the operation is not mandatory, a program to reduce weight and hence to take a little of the load off the cardiovascular system as well as to relieve the intra-abdominal tension is most helpful to the patient, to the surgeon and to the anesthesiologist.

Mental Attitude.—The mental attitude with which the patient considers the impending operation is important, and every effort should be made to reassure her that her welfare and comfort are

*Read at the meeting of the Arkansas Medical Society, Hot Springs, Arkansas, May 30, 1955.

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as important to the surgeon as to herself. The details of the procedure and the hospital routine should be discussed ahead of time so that the patient encounters as few unexpected situations as possible.

Bowel Habits.—Since bowel habits are often of prime importance from the patient's viewpoint, it is well, if possible, to see that she is given cathartics when necessary and to explain that for a time after the operation there is no necessity for the bowels to move and that therefore no effort will be expended on them. If the patient has other foibles, it is well to cater to them. If, for instance, she is used to a small toddy before meal time, it is wise to see that it is available in the postoperative period.

Laboratory Tests.—Specifically, there are certain tests that one should make. Urinalysis should be done preoperatively on all patients; it may reveal an unsuspected renal condition or unknown diabetes. A roentgenogram of the thorax gives information on the pulmonary fields and bronchi, and, in addition, shows the cardiac size, possible tortuosity of the great vessels, the presence of fluid in the pleural space, and, occasionally, metastatic lesions in bones. Especially when dealing with malignant disease, the report of nodules in the pulmonary fields or of questionable areas in the ribs makes one's approach to the primary lesion of much less importance and makes the comfort and ease of the patient the basic consideration. An electrocardiogram should be made when there is any question of the present cardiac status or of previous cardiac difficulties, but of equal importance is the patient's ability to do physical work without distress. Blood counts and possibly the examination of blood smears or the determination of the hematocrit reading may help establish the presence of anemia and, to some extent, the presence of dehydration.

If the patient has been on restricted intake of fluid because of nausea, vomiting or an indwelling nasal catheter, or if there has been excessive loss of fluid because of diarrhea or drainage from a fistula, then temporary hemoconcentration may occur so that the true anemia is not noted until the patient is in a better state of hydration. Such a patient should have fluids sufficient to replace obvious losses and insensible losses through the skin and lungs and to produce a urinary output of at least 1,000 cc. per day. Five per cent solution of glucose is administered in whatever amount of isotonic saline solution one desires to give, and any additional glucose is given in sterile water. Although numerous combinations of fluids are available for intravenous use, it behooves the sur-

geon to utilize to the best advantage those with which he is familiar. The more nearly the patient's body fluids and their chemical constituents are restored before operation, the more likely is the patient to have a satisfactory postoperative course and to avoid disturbances of electrolyte metabolism.

Preoperative Preparation.—The older patient usually needs less preoperative medication than does the more active younger one; hence, the doses of drugs given preoperatively should be reduced, although the requirements for atropine are much the same for most adults. Varicose veins cannot, of course, be cured before other surgical procedures are performed, but postoperative difficulties from such veins can be reduced by wrapping the patient's legs with ace bandages before operation. Thus the varicosities are reduced and the flow of blood expedited in the deeper vessels.

Surgical Treatment Versus Risk Involved

By the time consideration has been given to the over-all care of the patient as well as to specific problems and tests, the surgeon has already, consciously or not, reviewed in his own mind several additional questions.

1. Does the condition threaten the life of the patient?
2. Will the condition threaten the life of the patient?
3. Would an operation pose a threat to the life of the patient?
4. Is the relief offered by surgical treatment worth the risk?

Emergency conditions such as twisted cysts, severe vaginal or abdominal hemorrhage and incarcerated hernias either are threatening the patient's life immediately or, in all probability, will do so in a short time. Therefore, the surgeon must do the best he can to prepare the patient in a few hours to take the risk of surgery. Malignant lesions also threaten the patient's life and will cause death unless destroyed. However, the time element is not so acute, so that 1 to several days can be utilized to evaluate the patient's general condition and to reduce any factors affecting the operative risk. With malignant disease, one must weigh the alternative possibility of control with irradiation, but treatment the patient must have if she is to survive.

Sometimes, the conditions carry a future threat to the life of the patient. Fibroids are benign but occasionally undergo sarcomatous changes. A cyst that has been present for years may suddenly twist and become gangrenous. A femoral hernia may have been present for 20 or 30 years without

causing difficulty, only to become strangulated without warning. A submucous fibroid may ulcerate and cause severe hemorrhage. Postmenopausal bleeding is a symptom never to be taken lightly. It frequently is the only sign of malignant disease, and when it recurs after dilatation and curettage with negative findings, hysterectomy may well be indicated. Carcinoma in situ is seen not infrequently in older patients; while it is not a threat as long as it is in situ, the situation changes drastically when invasion occurs.

The question of the risk of surgical treatment is an all-important one, and one that no single surgeon can answer for all others. It is an unalterable fact that surgical treatment causes some risk to the patient's life, and this risk is greater in the older patient than in the younger. It is not so much that the surgical procedure is more difficult or that the incision will not heal as it is that age has produced in the heart, lungs, vessels and other tissues changes that reduce the recuperative margin. This is the margin between recovery and death to which the surgeon pushes the patient by his activities. In a young person the margin is wide and the patient tolerates, overcomes and recovers from all types of severe and prolonged insult to the body. In the older person the margin may be quite narrow by virtue of diseased organs. Therefore, it behooves the surgeon to give adequate thought to preoperative preparation and to do the operation rapidly, accurately and without lost motions. Fluids and blood should be replaced during the operation, and an effort should be made to keep the blood pressure fairly well stabilized. In one group of 202 patients more than 60 years of age, Zeman and Davids¹ reported two deaths, one being from embolism and the other from bronchopneumonia. Thus, the mortality rate was a little less than 1 per cent, which is low for consecutive cases of all types. In a recent evaluation of vaginal hysterectomy² in patients in the age group 61 to 84 years, no deaths were found in more than 200 consecutive cases, but this does not mean that there may not be one or two, or even more, deaths in the next 200 cases. It does illustrate, however, that relatively large numbers of older women can undergo surgical treatment at minimal risk.

Is the relief offered worth the risk? Yes, when a malignant disease is present or an acute emergency has occurred. The risk is well worth taking unless the patient is in such poor condition that the surgeon is concerned about even the administration of anesthesia. The answer is "yes" also when incontinence, prolapse and the like are marked or incapacitating, as the risk of vaginal

hysterectomy and repair is reasonable and the results of surgical treatment for these symptoms are excellent. The answer is "no" if the symptoms are minimal and vague and if the disease process, for example descensus, is not far advanced. Needless to say, the mere presence of a uterus in a woman in a surgeon's office is not sufficient cause to warrant its removal.

With these thoughts in mind it would be well to consider some specific lesions in the various major categories.

Emergency Conditions

In pelvic emergencies in geriatric patients we at least do not have to consider the complications or results of pregnancy. However, twisted cysts may occur at any age and the sudden continuous pain, localized in the pelvis, and the presence of a tender palpable tumor make the diagnosis fairly certain. If there is evidence of loss of blood, the possibility of ruptured cyst or vein on the surface of a tumor or the broad ligament must be considered.

One of the confusing lesions in the differential diagnosis and one that is more common in older patients is diverticulitis; however, the onset usually tends to be slow, and the temperature and sedimentation rate are increased. The tenderness in the left lower quadrant may be marked, but the mass is usually of a very indefinite outline and the symptoms have frequently been present for days.

Acute appendicitis is generally atypical in patients more than 60 years old, and sometimes it may be associated with a right ovarian cyst. However, the treatment of either is exploration with minimal loss of time in preoperative preparation.

Incarcerated hernia is still another condition encountered in geriatric patients, and a small hernia may be missed unless the surgeon checks all of the hernial orifices as he should. Inguinal hernia is serious, but an incarcerated femoral hernia is deadly, with an expected mortality rate of 20 per cent if the tissues are strangulated, 40 per cent if the small bowel is involved and 60 per cent if the small bowel must be resected; therefore, immediate surgical treatment is indicated.³

Vaginal hemorrhage is not uncommon. When it occurs, inspection of the vaginal tract and cervix may reveal a prolapsing fibroid, polyp or malignant growth as the source of bleeding. Vaginal removal of the tumor and packing usually control the bleeding until the condition of the patient can be improved and the diagnosis can be established; then hysterectomy can be performed if indicated.

The rare emergencies, such as rupture of an enterocele, speak for themselves. They must be

treated at once, regardless of the patient's general condition. Incarcerated procidentia, although presenting an appalling aspect, is not as bad as it looks. It is most important to get indwelling catheters into place and keep the urinary tract working. If the concentration of blood urea is increased, large quantities of fluids to increase urinary output, followed by vaginal hysterectomy and repair, are indicated.

Chronic Conditions

The chronic conditions form the largest group of conditions for which surgical treatment is required in geriatric patients. Most of these are related to the gradual loss of tissue tone and the development of cystocele, rectocele, prolapse and incontinence. In the consideration of surgical repair, one must realize that the life expectancy of the healthy patient is in the neighborhood of 20 years at the age of 61, 12 to 15 years at the age of 71, and 6 to 8 years at the age of 81. If their symptoms of incontinence, pressure, bearing down, "womb falling out," and the like are causing limitation of normal activities and giving distress, then some form of support is indicated. Pessaries may help in selected patients with fair perineal tissues, but surgical treatment consisting usually of vaginal hysterectomy and repair is the one of choice and fortunately carries a very low risk. In a series, to be reported, of more than 200 consecutive cases of vaginal hysterectomy in patients 61 years old or older there was not a single death, and the risk even in this group of patients should not be more than 1 to 2 per cent. The morbidity rate and the incidence of postoperative complications are also low and the patients tend to recover satisfactorily. Since the difficulties with relaxation of the pelvic support are seldom single, usually both vaginal hysterectomy and repair, rather than either alone, are required. The results of surgical treatment are good, with persistent incontinence in only a few and with distressing occurrence of enterocele in an occasional patient.

Postmenopausal bleeding is always a problem because it so frequently is due to a malignant process; therefore, it cannot be disregarded. Nor is it fair to the patient to assume that the bleeding is due to hormonal disturbance or to senile vaginitis. One can delay surgical treatment for a few days or for a week or two when there seems to be a definite etiologic agent, but unless the bleeding promptly disappears, curettage should be advised. If curettage gives negative results, nothing more need be done, but if bleeding recurs, then a second curettage is advisable; if there is descensus

of grade 1 to 2 or more, vaginal hysterectomy should be considered.

Benign Tumors

A benign tumor often poses a quandary to the physician, principally because such a tumor is not known to be benign until after it has reached the pathologist's laboratory and no cancer cells have been found in it. Still, a surgeon cannot remove every little growth he feels. Fibroids are rarely malignant, and fibroids that have been under observation a long time and are not changing in size and are not causing symptoms can certainly be left alone. But the development of pain, discomfort, bleeding or discharge should be adequate warning that all is not well. A change in size of the fibroids or even a change in consistency is important, and above all the surgeon must beware of and explore at once a "new" fibroid.

Calcified tumors are generally benign, as evidenced by the fact that they have been present long enough for calcium to be deposited. Fibroids and dermoids are the ordinary calcified tumors, and in the geriatric patient the best tooth may be in her pelvis and palpable per rectum. Again in these tumors, change in size or position or the development of symptoms warrants vaginal or abdominal exploration.

Cysts in young girls are benign in a high percentage of cases, but the reverse is true in older women: in those past 70 years of age a cyst has a 70 to 75 per cent chance of being malignant. Therefore, even soft cysts should be investigated.

Finally, in this group of benign tumors one should include leukoplakia of the vulva. Kraurosis and leukoplakia often are seen together, but when leukoplakia of the labia occurs, especially in older women, carcinoma in situ, or even an early invasive epithelioma, may be present. Of course, any crack or thickening is to be considered invasive epithelioma until proved otherwise. Leukoplakia of the vulva is best treated by simple vulvectomy, a procedure that is quick, easy and requires only 6 to 10 days of hospitalization. Recurrence is common over a period of years, and the patient should be so advised **before** operation. When vulvectomy reveals invasive carcinoma, the treatment is a Bassett operation, that is, radical vulvectomy plus dissection of the superficial and deep pelvic nodes. These tumors are, on the whole, resistant to radiation, but radical surgical treatment offers a fair chance of cure. Even in patients whose ages are in the high 70's or low 80's, this operation should be considered. Local excision is a palliative procedure and should be so recorded in the operative notes.

Malignant Tumors

Malignant lesions of the vagina are rare enough to be more or less disregarded but the results are poor from all points of view.

Malignant lesions of the cervix are encountered frequently, although the average age for in situ carcinomas is about 40 years and that for invasive squamous cell epithelioma of the cervix is 48. Radiation therapy is the cornerstone of treatment in invasive malignant disease of the cervix, although in a nonobese patient in good general health a primary Wertheim operation may be performed more quickly and it offers excellent results. For in situ lesions, hysterectomy should be advised, and often this can be done vaginally. Repairs should be made if they are definitely indicated, as implantation of cells from an in situ lesion is practically unknown.

Carcinoma of the uterus is an entirely different type of cancer. Ninety per cent are adenocarcinomas and 85 per cent are of grade 1 or 2 malignancy. They start in a thick-walled organ and are slow to metastasize. The average age of the patients is 58 years, so that when bleeding occurs it is postmenopausal and it should give adequate warning. Hysterectomy along with bilateral salpingo-oophorectomy is the treatment of choice. The surgeon should always feel retroperitoneally for lymph nodes. It adds little or nothing to the operative time, and if enlarged nodes do happen to be present they can be removed. The diagnosis is established by curettage. If examination of frozen sections of the endometrium are confirmatory, the uterus can be removed and treatment finished on one trip to the operating floor. The 5-year survival rate in carcinoma of the fundus of the uterus is in the neighborhood of 75 per cent after adequate surgical treatment.¹

Malignant lesions of the uterine tubes, like those of the vagina, are rare. Carcinoma of the ovary is common in geriatric patients, although Randall and Hall² have shown statistically that the incidence is highest in persons whose ages are in the upper 40's and that the incidence decreases thereafter. Unfortunately, malignant tumors of the ovary give no symptoms early enough to be helpful, so that the only hope of really improving the prognosis lies in regular pelvic examinations and exploration of any adnexal mass. Needless to say, the more solid such a mass seems to be, the more likely it is to be malignant. If possible, all ovarian tissue should be removed on exploration particularly if a papillary, grade I lesion is present. Since the uterus is commonly involved, it is advisable to remove it along with the ovaries if the operation is proceeding reasonably well. Scattered,

solitary, metastatic growths in the omentum are easily removed, but extensive peritoneal spread can be checked only by radiation. There is one exception to this. If the malignant growth is a granulosa cell or theca cell tumor, then all the implants possible, as well as the uterus, should be removed. The incidence of coexistent malignant disease of the uterus and granulosa cell tumor in persons more than 60 years of age is more than 10 per cent; hence, hysterectomy should always be done when a granulosa cell tumor is removed.³

Postoperative Care

The geriatric patient may not have too much of a problem after a pelvic operation, since such a procedure often upsets her very little. She should be given adequate amounts of fluid intravenously until the intake by mouth is sufficient for a urinary output of 1,000 cc. per day. If the patient has been well prepared with fluids preoperatively, then postoperatively there is need only to replace the fluid lost from urinary excretion, diarrhea or vomiting, and the fluid lost through the lungs and skin, which is estimated at 1,000 cc. per day under average conditions but which may be more in hot weather, when sweating is occurring. These fluids should be given slowly so as not to overload the circulation, and it is just as well to avoid use of saline solutions in the first or second liter of fluid while the output of urine is diminished. Later 1,000 to 2,000 cc. of 5 per cent solution of glucose in water and 1,000 cc. of 5 per cent glucose in isotonic saline solution given daily should supply the requirements for fluid, chloride and sodium.

It is not necessary to give potassium when everything is going well, but if fluids must be used intravenously for 3 or 4 days it is well to add 40 mEq. of potassium chloride to one bottle of fluid per day. Vitamin supplements either should be added to the fluids for intravenous use or should be given by mouth.

Postoperative sedation should be minimal. It is actually less necessary than in younger patients. The patient should be gotten out of bed as soon as possible, in 24 hours anyway, and encouraged to walk both to increase the circulatory rate and to stimulate deep breathing. Deep breathing is especially important, as pulmonary complications are the most common cause of postoperative death in the geriatric patient and everything possible should be done to prevent atelectasis and pneumonia. If the patient has varices, then the ace bandages applied before the operation should be kept on for several days longer.

The patient should be encouraged to eat. Well-prepared food should be offered, and the appetite

frequently can be stimulated by the judicious use of alcohol. Proteins given by mouth are cheaper and are better assimilated than amino acids given by vein, and they are more appreciated by the patient.

Elimination, both voiding and defecating, is frequently a problem; if it is necessary to use indwelling catheters longer than a day or two, then it is advisable to administer a urinary antiseptic. If the patient's bowels do not move readily, frequent rectal examinations for impaction should be made and the bowels activated by mild cathartics or enemas as necessary.

Finally, it should again be emphasized that surgical treatment should not be avoided purely on the basis of the patient's age. Other factors being equal, an older patient's tissues heal just as well and practically as quickly as those of a young person. However, older patients do offer a challenge to the surgeon in the over-all treatment of their problems, and they do require especial attention in the evaluation of their hearts, vascular systems, lungs and kidneys. When this attention is given and when attention is given to the fine details of fluid and electrolyte balance and to sedation, then the surgical response of the patient and the postoperative results are highly gratifying and well worth the efforts expended.

Summary

In this resume of some of the basic considerations of gynecologic surgery in the geriatric patient, emphasis is placed, first, on the total problem the patient presents and, second, on the infirmities to which she is liable because of her years. The cardiac reserve must be evaluated, any loss of weight must be investigated and the mental attitude and particular habits of the patient must be considered. Specific preoperative tests are discussed and the necessity of treating the dehydrated anemic patient before operation is pointed out.

The problems presented when the lesion is an immediate threat or a possible threat to life are considered, and then the risk of surgical treatment and the question of the relief offered by such treatment are discussed.

The specific lesions are classified and briefly discussed in four categories: emergencies, chronic conditions, benign tumors and malignant tumors of the pelvis. The surgical considerations are mentioned.

In the matter of postoperative care, stress is placed on intake of fluid, sedation, getting the patient back on an adequate diet, and her return to normal habits.

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WHAT'S NEW IN PEDIATRICS*

JOSEPH L. ROSENZWEIG, Hot Springs

To attempt a complete coverage of "What's New" in pediatrics in a twenty-minute discussion is too Herculean a task for both audience and speaker, and I shall not burden either of us with such an effort. Rather, I have chosen a few recent topics which I think should be of interest to you, and shall try to cover only their most practical aspects.

Prevention of Retrolental Fibroplasia: First recognized as a disease of premature infants in 1942, retrolental fibroplasia is now the chief cause of blindness in children. It is a major problem in the care of premature infants.¹ Since its recognition considerable investigation and theorizing have led to various explanations, and no one etiologic agent has been found to cause all cases.

It is possible that numerous agents may cause RLF. However, this clinical entity is almost always associated with oxygen therapy.¹ Experimental work on newborn rats, mice, kittens, and puppies has revealed that high concentrations of oxygen for long periods of time produce changes resembling those seen in human RLF.² Analyses of this malady in human prematures very strongly support such a belief. Thus, the oxygen pendulum must swing back from its position of only a few years ago when great effort was expended to increase oxygen concentration to a maximum in caring for the premature infant. But we must be cautious lest it swing back too far and result in inadequate oxygen therapy. A happy medium can be reached wherein one supplies adequate oxygen to prevent increased mortality rates, and still keeps it at a level low enough to minimize the production of RLF.³

Although no exact figures can be given, it is safe to say that the premature infant who receives oxygen at a concentration of less than forty per cent for less than forty-eight hours is likely to escape permanent eye changes from RLF.⁴ A brief plan for oxygen therapy would be as follows:²

1. Limit oxygen to the amount compatible with the physical well-being of the infant. Give it only to the cyanotic infant, and then at less than forty per cent concentration.
2. Give oxygen on order only, and not as a routine.
3. Make frequent attempts to discontinue it, and resume it only if cyanosis recurs.

4. Use compressed air instead of O₂ if aerosol therapy is indicated in the non-cyanotic infant.
5. Frequent samplings of oxygen concentrations should be made. This should be done with an accurate oxygen analyzer. A regular oxygen flowmeter is entirely unsatisfactory for such evaluations.

Tube Feeding of Premature Infants: For years very small premature infants have been fed with various devices—Medicine dropper, Breck feeder, nipple, or repeated gavage feedings. Associated with such procedures is the presence of exhaustion from the nursing effort and/or aspiration of milk. Both such factors probably affect mortality.⁵

Of benefit in this problem is the use of an indwelling gastric tube for intermittent feeding. Since the advent of plastic catheters this procedure has been simplified, made safer, and is in use in many leading premature centers. The indwelling tube is beneficial for the very small (under three pounds), especially those who tire easily when other methods of feeding are attempted. Those with poor sucking or swallowing reflexes, congenital abnormalities, or mouth infections also are candidates for the use of this technique.

Several different types of catheters have been used.^{5, 6, 7} Their expense is minimal, and they contribute to an economy of life as well as of nursing costs. Perhaps the simplest, cheapest, and most readily available technique is to use regular polyethylene tubing. Its size can be varied to preference, but one should not exceed an internal diameter larger than that which will receive a twenty gauge needle. The distal end is blunted simply by giving the tubing a quick snap. This stretches the end to a soft, somewhat rounded tip which allows for easier passage plus less likelihood of injury to the wall of the stomach. Next, a sharp blade is used to cut two perforations in the side of the tube.⁸ Sterilization is apparently adequate after immersion in 1:1000 zephiran solution for 24 hours.⁹ Such tubing may be left in this solution for longer periods of time without damage. Prior to use it is rinsed with sterile water or saline. Insertion into an infant is a very easy procedure. The infant's head is placed in a neutral position, and a length is marked off on the tube equal to the distance from the glabella to the ensiform cartilage. The tube is introduced gently through the nares until this mark is reached, and then it is

*Read before the Seventy-ninth Annual Session of the Arkansas Medical Society, June 1, 1955, at Hot Springs.

taped in place.⁵ For feedings it is necessary only to attach a syringe to the needle, and with gravity or gentle pressure introduce the formula. A small amount of sterile normal saline or water (0.5 cc.) is used to flush the tube, and the open end of the needle is closed by a stylet.

It seems wise to remove this tube at five-day intervals to help prevent esophageal irritation. It is reinserted in the opposite nostril after a brief rest period. One should be cautious that the tube is not too long lest it cause damage to the gastric wall. Lastly, a reminder to guard against over-feeding simply because there is an open route for the introduction of formula.

Treatment of Erythroblastosis: Erythroblastosis, or, using a preferable term, hemolytic disease of the newborn, is no longer a clinical museum piece. It is a potential problem faced often by anyone who works in the fields of obstetrics or pediatrics. Much remains to be learned regarding etiology, prevention, and diagnosis, but a great deal is already known.

The treatment of choice—replacement transfusion for all except possibly the mildest cases—is no more looked upon as an "heroic" measure. This procedure, which once was done only in the highly specialized centers, now has been simplified to the extent that it can be performed in practically any hospital. It is a part of everyday practice. Our responsibility is to recognize that erythroblastotic infants can be saved, and that they can be spared the neurologic sequelae which used to be associated with a great number of the survivors.⁹⁻¹⁰ Thus, it is our duty to equip ourselves and our hospitals so as to be able to handle such cases. Otherwise, we should make arrangements for the prompt transfer of such cases to areas where replacement therapy is available.

Herpangina: Herpangina, or vesicular pharyngitis, was first described in 1920.¹¹ Although the original description was excellent, it is only recently that this disease has come into prominence in the literature and in our everyday practices. More recent studies pretty well implicate strains of Coxsackie type viruses as etiologic agents.¹²⁻¹³ Having seen a minor epidemic in my own community last summer, I feel that it merits attention here.

This infection usually attacks patients under ten years of age, is a common summertime illness, and has a distribution throughout the country.¹⁴ The disease has a sudden onset with high fever, the fever lasting from one to four days. Anorexia and dysphagia are prominent. Occasionally headache and generalized muscle pain have been noted. In the child old enough to complain, sore

throat is prominent. In the majority of cases positive findings are limited to the throat. Key lesions are found on the soft palate and anterior faucial pillars, and present a rather characteristic appearance. They are seen as grayish-white papulo-vesicular lesions one to two millimeters or less in diameter. They present as discrete vesicles surrounded by erythematous areolae, eventually rupture, and assume the characteristics of ulcers with grayish-yellow discoloration.¹⁴

The disease has a benign, self-limited course, and usually lasts from two to four days. Treatment is symptomatic, and no serious complications have been reported.

Visceral Larva Migrans: Recent studies by Beaver and his co-workers have presented us with a "new" disease, and a plausible explanation for many previously confusing clinical pictures.¹⁵ I refer to the condition which they have termed "**Visceral Larva Migrans.**" This name was given because of its relationship to the better known cutaneous larva migrans. Both usually are caused by infective stage larvae of nematode parasites ordinarily harbored by animals other than man.

The disease occurs predominantly in the one and one-half to six year age group, and is characterized chiefly by sustained eosinophilia, pneumonitis, and hepatomegaly.¹⁶ The clinical picture is felt to be due to tissue damage by the migrating larvae and to allergic responses to their products. The individual may be entirely asymptomatic, and the disease picked up by accidentally recognizing conspicuous eosinophilia. On the other hand, the patient may experience weeks of lassitude, recurrent fever, failure to gain weight, and have clinical and X-ray evidences of pneumonitis and/or hepatomegaly. Leukocytosis ranges from 15,000 to 80,000 with the eosinophiles ranging from thirty to eighty per cent; in fact, counts may vary in the individual patient.¹⁶ Although visceral larva migrans is not the cause for all cases of eosinophilia and pneumonitis, it is a not uncommon condition, and explains a great number of bizarre cases with such findings.

The clinical picture usually is due to infestation with larvae of either *Toxocara canis* or *Toxocara cati* (most likely *T. canis*), the common ascarids of dogs and cats.¹⁵ Infection occurs when the child eats dirt containing feces of a worm-bearing animal. The larvae hatch in the upper section of the small intestine, migrate "wildly" through organs and tissues, and produce the local granulomatous lesions and eosinophilia. Since man is an abnormal host, the parasite does not complete its life cycle and egg laying adults do not reach the human intestine. Therefore, diagnosis cannot be

made from stool examinations. Definite diagnosis rests on liver biopsy, although agglutination studies may turn out to be helpful.¹⁷

There is no specific treatment, but most patients will outlive their infection. Our job as physicians is to be aware of the condition, to be sure the patient uses prophylaxis against re-infection.¹⁶

Hyperimmune Antirabies Serum: We are all aware of the frequent problems that arise in the management of dog bites. Knowing that there is slight danger of neuromuscular involvement with the use of rabies vaccine we dislike giving it unless administration seems imperative. Yet, we are dealing with a one hundred per cent fatal disease, and our only effective treatment is prophylaxis. In view of the frequency of this situation, I want to mention briefly a new adjunct now available for prophylaxis.

Lederle Laboratories now market a concentrated serum derived from hyperimmunized horses, and call it antirabies serum. It is only recently that this serum has been used in the United States for the prophylaxis of rabies in man, but it seems to have a definite place in our armamentarium against rabies. I emphasize that it is used primarily as an adjunct to vaccine therapy and not in place of it. It has its principal value after severe exposure such as from multiple bites on face, head, or neck bites.¹⁸ Also, it may be used prior to vaccine therapy in some situations where the biting animal is healthy and can be observed closely.¹⁹ I make no attempt to outline its use, but heartily recommend your obtaining a reprint of the WHO report on rabies.

Accidents: In conclusion let me remind you that in spite of "What's New" in the field of pediatrics, we have an old enemy present—Accidents are still the chief cause of death in children.

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PRELIMINARY PROGRAM

ARKANSAS MEDICAL SOCIETY

Little Rock — April 23, 24, 25, 1956

The State meeting will be preceded by a program of the Cancer Society on Sunday, April 22nd. The Auxiliary of the State Medical Society will meet concurrently, with its own program. In addition to the Scientific program listed below, there will be meetings of the Council and other official meetings, to be announced later. Also there will be held on Monday and Tuesday, April 23 and 24, a golf tournament and a skeet and trap shoot, with prizes to be awarded. It is also hoped that on Monday and Tuesday and Wednesday, April 23, 24, and 25, there will be organized tours of the Greater Little Rock area, including the New Air Base. It is hoped that many private reunion dinners, alumni dinners, class dinners, and fraternity dinners will be organized by interested individuals for the early dinner hour on Monday, April 23, and that we might be notified of them so that proper publicity can be given in the Journal and the official program.

The Monday Evening program is geared as an interesting public relations effort. The public is to be invited to visit the exhibits from 5:00-7:00 P.M., and then will be invited to attend the program in the Main Hall of the Robinson Auditorium, seating 3,000, where the Ciba Pharmaceutical Company, Inc., will originate its coast-to-coast television show, "Medical Horizons," featuring its own professional cast, and considering a topic from our own state. You are urged to invite your lay friends to attend with you.

A tremendous party is planned for us on Tuesday, April 24, starting about 5:30 P.M., Hotel Marion Continental Room, sponsored by the Pulaski County Medical Society. There will be no speeches at the Annual Dinner-Dance (formal, that is), but there will be a very enjoyable informal program during the evening, arranged through the Auxiliary of the Pulaski County Society, probably with the help of other members over the State.

Since the week of April 22, 1956, is American Medical Education Week, it is fitting that the Wednesday, April 25, program be turned over to our Medical School. The program for this day is not yet completed, but will include formal presentations at the Auditorium, luncheon at the new Medical Center, and an afternoon open-house at the new Medical Center, with specially-arranged tours, teaching rounds, clinic rounds, and closed-circuit television programs from the operating rooms and clinics to the new large Medical School

Auditorium at the new Center. The program this year will be held at the Hotel Marion and the Robinson Auditorium; regular shuttle-bus service between the two will be available daily.

All of the commercial and scientific exhibits will be housed in the large Exhibit Hall of the Auditorium. All of the general morning sessions will be in the Lecture Hall of the Auditorium. All of the luncheons will be in the Hotel Marion. The afternoon symposia will be divided between the Hotel Marion and the Robinson Auditorium. The Hobby Exhibit will be in the Robinson Auditorium Exhibit Hall.

Registration will be in the Hotel Marion Lobby Sunday, April 22, and in the Exhibit Hall, Robinson Auditorium, Monday through Wednesday, April 23-25. Special phone arrangements will be available at the registration desk in the Exhibit Hall, with a fuller call-system for doctors worked out, using our regular "Doctor's Exchange," working through these special phones.

All of the outstanding speakers obtained will speak before the general session, as well as before a particular specialty symposium. The specialty luncheons and symposia are open to all.

Better radio, TV, and newspaper publicity during the meeting is planned through the use of a regular News Room at the Auditorium, and a Press Table at the general sessions, and through regularly scheduled press conferences, and radio and television appearances of our speakers.

One special feature in the Exhibit Hall will be a question and answer booth, manned during the session by representatives of the various medical specialties, prepared to discuss with you any matter or problems relating to their specialty and your interest or case.

The commercial exhibits will be outstanding. Already 44 commercial exhibit spaces have been sold, insuring a wide and interesting variety of displays. Applications have also been received for 20 scientific exhibits from individuals, clinics, schools, etc. If you are interested in a scientific exhibit yourself, please notify us promptly. And if you are interested in participating in the Hobby Exhibit, also please notify us promptly.

That is a brief outline of how the Arkansas Medical Meeting, April 23, 24, and 25, 1956, is shaping up. This is your meeting, planned for you and with you in mind. Please talk up interest at home, and plan to attend with a large delegation from your own county medical society.

Joseph A. Norton, Chairman,
Scientific Program and Local
Arrangements Committee

Preliminary Program

LITTLE ROCK — APRIL 23, 24, 25, 1956

SUNDAY, APRIL 22

REGISTRATION—2:00 - 4:00 P.M.—Lobby of Hotel Marion

MONDAY, APRIL 23

EXHIBITS OPEN FROM 8:00 A.M. to 5:00 P.M.—Exhibit Hall, Auditorium

- 9:00 - 9:20 INVOCATION; PRESIDENT'S ADDRESS—Auditorium
- 9:25 - 9:45 Dwight Murray, President, American Medical Association—Auditorium
- 9:50 - 10:10 R. L. Sanders, Immediate Past President, Southern Medical Association—Auditorium
- 10:15 - 10:35 MEDICINE—Julian Ruffin, Duke University, "Peptic Ulcer"—Auditorium
- 10:35 - 11:00 VISIT EXHIBITS—Exhibit Hall, Auditorium
- 11:00 - 11:20 MEDICINE—Robert Huseby, University of Colorado, "Palliative Therapy of Carcinoma of the Breast"—Auditorium
- 11:25 - 11:45 RADIOLOGY—John Hope, Philadelphia, "The Normal Chest of Infants and Children—Facts and Fallacies"—Auditorium
- 11:50 - 12:10 GENERAL PRACTICE—R. A. Davison, University of Tennessee, "Teaching General Practice in the Medical School"—Auditorium
- 12:30 - 2:00 LUNCHEONS—Hotel Marion
 MEDICINE—Elmer Purcell, University of Arkansas, "Fever of Undetermined Origin"
 RADIOLOGY—
- 2:00 - 4:00 SYMPOSIA—
 ARKANSAS ACADEMY OF GENERAL PRACTICE—R. A. Davison, University of Tennessee, "The Relation Between General Practitioners and Specialists"—Auditorium
 MEDICINE—
 RADIOLOGY—
- 4:00 - 5:00 VISIT EXHIBITS—Exhibit Hall, Auditorium
- 4:00 - 5:00 HOUSE OF DELEGATES—Auditorium
- 5:00 - 7:00 EXHIBITS OPEN TO PUBLIC—Exhibit Hall, Auditorium
- 6:00 - 7:30 SPECIAL REUNIONS, ALUMNI, FRATERNITY, PRIVATE DINNERS
- 8:00 - 10:00 Ciba Pharmaceutical Company, Inc.—Television Show "Medical Horizons"
 Nationally Televised from Main Hall, Auditorium

TUESDAY, APRIL 24

EXHIBITS OPEN 8:00 to 5:00 P.M.—Exhibit Hall, Auditorium

- 9:00 - 9:20 SURGERY—(Topic to be announced)—Auditorium
- 9:25 - 9:45 PEDIATRICS—Clement Smith, Boston, "Why and How to Take Care of Premature Infants"—Auditorium
- 9:50 - 10:10 RADIOLOGY—Harry Spence, Dallas, (Title to be announced)—Auditorium
- 10:15 - 10:35 OBSTETRICS—Charles Paul Hodgkinson, Henry Ford Hospital, Detroit, "Hypofibrinogenemia"—Auditorium

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- 10:40 - 11:00 SURGERY—(Topic to be announced)—Auditorium
- 11:00 - 11:20 GYNECOLOGY—Willard Cooke, University of Texas, "The Indications for Treatment of Uterine Myomata"—Auditorium
- 11:25 - 11:45 OPHTHALMOLOGY—A. E. Braley, University of Iowa, "Diagnosis and Treatment of External Inflammation of the Eyes in Infants"—Auditorium
- 11:50 - 12:20 MEMORIAL SERVICE—John Wm. Smith, Little Rock—Auditorium
- 12:30 - 2:00 LUNCHEONS—Hotel Marion
- SURGERY—
- PEDIATRICS—
- EYE, EAR, NOSE, THROAT—
- OBSTETRICS-GYNECOLOGY—
- UROLOGY:
- 2:00 - 4:00 SYMPOSIA—
- SURGERY—Hotel Marion
- PEDIATRICS—Arkansas Academy of General Practice—Auditorium
- OBSTETRICS-GYNECOLOGY—Hotel Marion
- UROLOGY—Pyelographic Session—Hotel Marion
- 10:00 - 4:00 EYE, EAR, NOSE, THROAT—Hotel Marion
- Chairman's Address—N. B. Burch, Hot Springs
- Charles S. Lane, Jr., Fort Smith
- "Surgical Problems Involved in the Removal of Glomus-Jugulare Tumors"
- Harold G. Tabb, New Orleans
- "Stapes Mobilization for Restoration of Hearing in Otosclerosis"
- LUNCHEON—Business Meeting
- Max Baldrige, Texarkana, "Pathological Findings in Eucleated Eyes"
- A. E. Braley, University of Iowa, "Surgery of the Lacrimal Gland"
- 4:00 - 5:00 VISIT EXHIBITS—Exhibit Hall, Auditorium
- 6:00 - 8:00 SOCIAL HOUR—Pulaski County Medical Society, Hosts—
- Continental Room, Hotel Marion
- 8:00 - 12:00 ANNUAL DINNER-DANCE—Ballroom, Marion Hotel—Tommy Scott's Orchestra
- SPECIAL ENTERTAINMENT—Pulaski County Medical Society Auxiliary
- AWARDS—Golf Tournament and Skeet and Trap Shoot

WEDNESDAY, APRIL 25

EXHIBITS OPEN 8:00 A.M. - 12:00 Noon (Exhibits to be dismantled after noon)—Exhibit Hall, Auditorium

Program of this day in charge of University of Arkansas School of Medicine, to be presented at the Auditorium in the morning, Luncheon at the New Medical Center on West Markham Street, and Afternoon Program at the New Medical Center, to be announced later.

- 2:00 - 3:00 HOUSE OF DELEGATES—Auditorium
- 3:00 - 3:30 FINAL GENERAL SESSION—Auditorium

— ★ Editorial ★ —

WHO IS GOING TO PAY SANTA CLAUS?

Every Arkansas physician is interested to know why the medical profession is registering opposition to House Resolution 7225. It passed by an overwhelming vote in the House, only 31 Congressmen voting "NO" on the measure, which was kept under the "gag" rule, limiting the debate. All Arkansas Congressmen voted for the bill, we don't know why. The Senate has yet to act.

The bill would add disabled workers over 50 to a Federal dole, operated by the Social Security. A physician would necessarily certify if a man was disabled. We can see the rush of dead-beats to the doctor's office to be certified. Of course, there will be the deserving.

Votes will be made or lost, depending upon a Congressman's ability to produce certificates of disability. That's pressure by a Congressman, and it's pressure on a physician. Some physicians will sign under pressure. That makes it all the more difficult for the honest physician, and for the honestly disabled.

And the **next** step. Will it be to lower the age from 50 to 40 or 20? Only the planners know, and some of the planners are Congressmen.

Taxes will be kept high, as the "social security" rises from time to time. In 20 years they are to be 9% of a worker's earnings—**before deductions**. Only the most stupid is fooled by the "half from the worker, half from the employer" clause. If the worker didn't earn the other half, too, he wouldn't be on the payroll.

Other taxes will have to support the program of an enforced charity, such as is planned. Even those monies collected as Social Security Taxes are now gone. This fund will have to be replaced by new taxes—chiefly of our younger generations, and our children.

Government physicians will have to be appointed to take care of these "disabled"—even some cases that are able to take care of themselves. This means a breakdown of a free choice of doctor or of hospital. It means the breakdown of the independent practice of medicine.

Seale Harris called Socialism the "stalking horse of Communism." House Resolution 7225 socializes the patient, and the physician, and destroys a magnificent American system of medicine, which is, to this hour, striving to provide more and better

medical care, even while it fights for its own freedom.

We urge our solons, in both Houses, to look on this Social Security System as it is. It advocates a step by step change from a democratic government to a totalitarian one. Someone called it the "welfare" state. A more accurate word is "Totalitarian State," which we all recognize.

At first, Social Security was a simple, small relief for the aged. This was in 1935. Next, the "relief" becomes bigger. This was in 1940. In 1946 it became much bigger (House Resolution 6000). Its obligations grew enormously, and its assets had changed from cash to government bonds. These bonds are to be redeemed in one way—more taxes (or in printing more paper money). In 1954 President Eisenhower added 10,000,000 to the "Security" rolls. More obligation for a financially unsound structure! These steps are not only steps to Socialism (Communism), they are also the steps to bankruptcy!

Someday we are going to have enough Congressmen in Washington who are willing to stand up above the common herd, and defy the "more and more" boys, and vote their convictions. Someday we're going to find men who will, if it's sound economy, vote against "Santa Claus."

Government is not responsible for the individual illness, and government should not extend to such functions. When government is interested in the individual case, Doctor, you are no longer his private physician, you are a government clerk—following rules made in a centralized, powerful Federal government—and you aren't free, anymore.

Fight House Resolution 7225. Call on your Senators, McClellan and Fulbright, to help kill the bill.

President Eisenhower's recent Conference on Education demonstrated some considerable defects in our present-day schools. Not the least of these defects was the charge that the school masters were teaching only the "fringes," and neglecting the fundamentals of an education.

We were reminded, by these charges, of a meeting of Editors of State Medical Journals held last November where these gentlemen discussed their troubles, their headaches, and their satisfactions.

It was generally agreed that many of the medical articles submitted by the average graduate, lacked considerable clarity of expression, and had to be "edited" closely, as to the use of words, and especially as to sentence structure. In other words, it was agreed that too few of our medical writers

know the ordinary rules of grammar. We felt the average writer was growing worse with each new crop. It was further agreed that it was probably within our province to ask the Deans of medical schools, and Admission Committees to re-instate some of the requirements for admission to medical colleges. These were to include considerable English, at least two languages, or a total of four years of language, advisedly, two years of a foreign language, and two or more years of Latin. It was concluded that more medical students are being sent to medical school without a proper background, at least without a background which enabled them to contribute to medical literature.

Perhaps the above observations would have passed without comment, had it not been for some suggestions in collegiate circles in our own state that certain high school subjects be dropped from the list of requirements for college students. These subjects were the Sciences, Languages, and, least understandably, English. In their places were to be substituted some of the "social sciences," and the "humanities."

Now we cannot pose as authorities on "social sciences" and "humanities," but we remember the "sociology" of our high school days with considerable derision. We are a little vague on "social sciences," and as old Latin scholars we are puzzled at those two words being such good bedfellows. As for the "humanities," we can be sarcastic or be kind. We will be kind. We are glad that certain forms of trades are being taught in our schools. The classes that train social workers, for instance. Heaven knows, they need training. Whether we need them or not is another question. We are alarmed, however when one of our college offers sixteen courses in "Theater," and one in Latin!

Maybe we're just old, and out-dated, but we'll bet a fifteen-dollar hat that if our young physicians had the advantage of three years of Latin, and three years of some foreign language, they would be able to express themselves more clearly, more accurately, more forcefully, and certainly in better grammar than they now seem able to do. We are asking our educators to send us students to our medical schools that have a knowledge of the fundamentals of expression, that they know how to write well, and to talk clearly, and effectively. We believe this knowledge is obtained from work, in English grammar, and in the languages.

A LOOPHOLE

The recent attempts of the Communist-run International Labor Organization (I.L.O.) to con-

clude a treaty with the Government of the United States points up a loophole in our Constitution.

This loophole, specifically, would allow a President with only a handful of Senators—as few as four—to ratify and adopt a treaty which might nullify constituted law in the United States, and in our several states. Fortunately, this has not yet been accomplished, and President Eisenhower has, within the year, rejected an attempt by the I.L.O. to change our internal law.

Senators are sometimes absent from the floor, and we can envision a time when unscrupulous men of a left-wing (or Red-wing) taint, might take advantage of the situation. We trust our Senators McClellan and Fulbright, but, unfortunately, this trust does not extend to all their colleagues.

Senator McClellan has come out already in support of amendment to plug the loophole, and physicians will be wise to encourage Senator Fulbright to do the same. Both senators should support the Bricker Amendment.

ACT 172 OF THE 1955 LEGISLATURE

"AN ACT PROVIDING FOR A POST MORTEM EXAMINATION ON THE BODY OF A DECEASED PERSON, PRESCRIBING THE MANNER IN WHICH CONSENT WILL BE GIVEN, AND FOR OTHER PURPOSES."

Be It Enacted by the General Assembly of the State of Arkansas:

"Section 1. Consent for a licensed physician to conduct a post mortem examination on the body of a deceased person shall be deemed sufficient when given by the deceased if in writing and duly signed and acknowledged prior to his death or when given by whichever one of the following who assumes custody of the body for purposes of burial: father, mother, husband, wife, child, guardian, next of kin or in the absence of any of the foregoing a friend or a person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, consent of one of them shall be deemed sufficient.

"Section 2. After the examination provided herein has been completed the dead body shall be delivered to the relatives or friends of the deceased for burial.

"Section 3. This Act is cumulative and does not alter or repeal any law or laws now in effect."

This information should be available to all of the doctors in the State to clarify their positions legally for the obtaining of consent of post mortem examinations.

THE 1956 ARKANSAS MARCH OF DIMES

Although the number of polio cases in Arkansas in 1955 was only about half the average number of the previous five years, Arkansas will still have polio problems in 1956. The Salk vaccine is a major weapon against paralytic poliomyelitis, but it has not yet won the war against this disease.

The vaccine is not 100% effective and it will take considerable time yet, perhaps years, before all individuals most susceptible to paralytic poliomyelitis can be fully immunized against it.

In 1955 the March of Dimes of the National Foundation gave 171,000 cc. of Salk vaccine without charge to the State of Arkansas to initiate a state-wide vaccination program.

To pay for research, education and aid to polio patients, the March of Dimes needs \$47,600,000 in 1956.

A brief review of the record of the National Foundation for Infantile Paralysis in Arkansas, should help to orient physicians to the many services to patients and the professions which have been made possible by the March of Dimes since 1938.

Over \$3,470,000 has been spent in Arkansas by local chapters for the care of polio patients.

23 National Foundation scholarships and fellowships have been awarded to Arkansas residents.

Emergency aid in dollars and in equipment for polio patients has been generously supplied to Arkansas. In the first 10 months of 1955 a total of \$128,355 in emergency aid was sent to 38 Arkansas chapters by the national headquarters of the National Foundation. In the year 1954 the amount was over \$326,000 to 61 chapters.

A total of 14 tank respirators, 18 chest respirators and 2 rocking beds were sent into Arkansas as emergency shipments in the first 10 months of 1955. The previous year Arkansas got 52 respirators and 4 rocking beds.

ANNOUNCEMENTS

On Monday, April 23, 1956, at the Arkansas Medical Society meeting, Little Rock, the hours of 5:30-7:30 P.M. have been held open for alumni dinners, fraternity dinners, private dinners, or any association or organization dinners. It is hoped that many such dinners will be organized by interested individuals. In an effort to correlate those activities and to allow them proper full publicity in the official program of the meeting and in the State Journal, it is suggested that any such plans be sent through or to Robert Ross, 908 Donaghey

Bldg., Little Rock. Dr. Ross will help to find a place for the dinner, if so requested.

Joe Norton, General Chairman.

A Hobby Exhibit is planned for the meeting of the Arkansas Medical Society next April, from April 22 to April 25.

Those interested in exhibiting contact John McCullough Smith, Boyle Building, Little Rock.

Here's an invitation it's a pleasure to pass along. It comes from the Hawaii Medical Association, which is celebrating its Hundredth Anniversary April 22 to 29, 1956, in proper "Hawaii" as well as medical fashion. There will be a short but worthwhile professional program on Monday and Tuesday mornings, a spectacular Centennial Celebration Pageant Tuesday night, and a traditional *luau* (Hawaiian feast to you, Easterners) Thursday night, with Polynesian entertainment.

Write the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii, for reservations application forms.

EXAMINATIONS FOR FELLOWS IN I.C.S.

Four oral and four written examinations for Fellows in the United States Section of the International College of Surgeons will be conducted in 1956.

Oral conferences will be held in Chicago on January 23, April 16, August 6 and October 22. The written examinations will be conducted on January 30-31, April 23-24, July 23-24 and October 29-30.

Further information may be had by writing to the Secretariat of the United States Section, International College of Surgeons, 1516 North Lake Shore Drive, Chicago 10, Ill.

MEDICAL EDUCATION WEEK April 23-29, 1956

MEDICAL EDUCATION CONTRIBUTIONS

The A. M. A. Board of Trustees announced that it again has appropriated \$100,000 to be contributed to the American Medical Education Foundation for the support of medical schools. The California Medical Association presented a \$25,000 check to the AMEF, and the Utah State Medical Society announced an \$11,000 contribution.

Arkansas

TRAVELING

And Clipping Bits Here and There

PROBLEMS OF MEDICAL EDUCATION ON CONGRESS DOCKET

The role of advanced training in the over-all medical education picture will be discussed during the opening session of the 52nd annual Congress on Medical Education and Licensure to be held February 11-14 at the Palmer House, Chicago. The meeting will be sponsored by the A.M.A.'s Council on Medical Education and Hospitals, the Federation of State Medical Boards of the United States and the Advisory Board for Medical Specialties.

CONFERENCE ON RURAL HEALTH SLATED FOR MARCH

"Your Doctor and You" will be the theme of the 11th National Conference on Rural Health sponsored by A.M.A.'s Council on Rural Health, March 8-10 at the Multnomah Hotel, Portland, Ore. Chief topics to be discussed include: the family physician, mental health, programs for older people, prepaid medical care, and successful community enterprises. Ample time will be devoted to discussion and group participation.

An informal pre-conference session will be held for physicians only on Thursday morning, March 8, beginning at 9 A.M. Principal topic of discussion will be the relationship and responsibilities of a family doctor to his patients.

"To those of you who waited: sit down and write your check now while you have it in mind. Remember, this is an important year for the AMEF and medical education. If each and every one of us are going to affirm our belief in the high standards which are now taught in our medical schools; if you and I are going to stand up for our beliefs, then you and I must sit down and give."

—Elmer Hess.

MILLIONS FOR HEART RESEARCH

In the first decade of its existence the Life Insurance Medical Research Fund has given more than \$7,000,000 for heart research. This is the largest contribution made by any business-sponsored agency for the study of heart and circulatory diseases. The awards for 1955 total \$929,400, the largest for any year so far.

PUBLISHERS HELP MEDICAL SCHOOLS

Whitelaw Reid, chairman of the board of the New York Herald Tribune, has been appointed chairman of the Newspaper Division of the Committee of American Industry, a division of the National Fund for Medical Education, which is leading a nation-wide appeal to raise \$10,000,000 annually for the nation's medical schools. Working with Mr. Reid are 18 of the country's most prominent newspaper publishers.

ARCHBISHOP ASSAILS U. S. SOCIAL AID

Archbishop Patrick A. O'Boyle, of Washington, D. C., followed in the footsteps of the medical profession recently when he lashed out against any further extension of government social services.

In a sermon at the opening of the 41st national conference of Catholic charities, Archbishop O'Boyle said that the American way of life has provided the opportunity for persons of all religious beliefs to establish and maintain organizations of charity for the service and care of those in need. But he noted that in the last two decades there had been a multiplication and development of the social services under governmental auspices.

He acknowledged that this increase had arisen from the problems and social difficulties in the complex industrial society of today. But he added:

"It will be a sad day for free men, it will be a catastrophic event blasting America's foundation of freedom, it will be an eventuality traitorous to America's very substantial tradition of a glorious panoply of social services under religious and private auspices if either the present network or the future extension of governmental social services causes in any manner the gradual smothering or ultimate suppression of the works of Christian charity."

REPORT ON ACTIONS of the

HOUSE OF DELEGATES

American Medical Association

Ninth Clinical Meeting

Nov. 29 - Dec. 2, 1955

NOTE: This is a summary of actions which are timely and important. For this reason it is presented almost in toto.

Boston, Mass., Dec. 2—Social Security, the report of the Committee on Medical Practices, grievance committees and revisions of the code of medical ethics were among the major subjects of discussion and action by the House of Delegates

at the American Medical Association's Ninth Clinical Meeting held Nov. 29 - Dec. 2 in Boston.

Named as the 1955 General Practitioner of the Year was Dr. E. Roger Samuel of Mount Carmel, Pa., whose selection by a special committee of the Board of Trustees was announced at the opening session on Tuesday. Dr. Samuel, a former member of the House of Delegates and a general practitioner for 35 years, received the medal and citation presented annually for community service by a family doctor.

Dr. Gunnar Gundersen, A.M.A. Board Chairman, who made the award to Dr. Samuel, also presented a special citation to Dr. Torald Sollmann of Cleveland, Ohio, charter member of the A.M.A. Council on Pharmacy and Chemistry for over 50 years and its chairman since 1936. Dr. Sollmann, 81 years old, was honored for his "outstanding service to the medical profession and on behalf of the advancement of medical science."

Total registration at the end of the third day of the meeting had reached 7,027, including 3,672 physicians.

Social Security

Major legislative policy action taken at the Boston meeting involved H.R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the U. S. House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash benefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H.R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective non-political improvements to the Social Security Act, for the benefit of all of the American people;

"That the American Medical Association pledges its wholehearted cooperation in such a

study of Social Security in the United States, and will devote its best efforts to procuring and providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

OASI Coverage of Physicians

In another action on social security, the House passed the following resolution designed to determine the exact attitude of physicians toward compulsory or voluntary coverage under the social security system:

"Whereas, Misunderstanding exists about the position of the medical profession on the question of the inclusion of physicians in the Old Age and Survivors Insurance provisions of the Social Security Act; therefore be it

"Resolved, That the House of Delegates of the American Medical Association recommend to state societies that they poll their entire membership on this question and that the results of the poll be transmitted to the Board of Trustees of the American Medical Association as soon as possible."

Report on Medical Practices

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity. The resolution, adopted with the proviso that it is subject to review by legal counsel, includes the following points:

"That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association;

"That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners; . . .

"That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school;

"That the American Medical Association approve of the medical school teaching programs

which afford the medical student opportunity for experience in the general practice of medicine;

"That the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the County Medical Society concerned;

"That this committee cooperate in every way and assist the Public Relations Department of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practice, and

"That this committee use its full influence to discourage any arbitrary restrictions by hospitals against general practitioners as group or as individuals."

In a complementary action on the same subject, the House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All non-surgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.

2. The various specialty boards shall be encouraged to reappraise the practice restrictions on their board diplomates.

Miscellaneous Actions

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services";

Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of an A.M.A. committee to study the prevention of highway accidents;

Commended the Women's Auxiliary of the A. M. A. for its financial contributions in support of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the A.M.A. Law Department on its studies of professional liability;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual; and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.

PERSONALS AND NEWS ITEMS

Alastair D. Hall, Little Rock, has been appointed medical director for Pioneer Western Life Insurance Co.

H. A. Ted Bailey, Jr., of Little Rock recently returned to his practice after completing a course in Rhinoplastic Surgery in New York City. He will return to New York for further study in May of 1956.

Ben N. Saltzman, Mountain Home, is serving Rotary International as a member of the 1956 Rotary Institute Agenda Committee.

George W. Allen has opened offices at 807 South Greenwood Avenue in Fort Smith for the practice of internal medicine.

Raymond C. Goodman has joined Holt-Krock Clinic in Fort Smith. He will limit his practice to anaesthesia.

Registered at the American College of Surgeons meeting in Chicago October 30 were: H. Fay H. Jones and Robert M. Eubanks, of Little Rock.

James W. Headstream was the speaker at a recent meeting of the McCracken County Medical Society in Padauch, Kentucky. His subject was "Diagnosis and Management of Problems Encountered in Pediatric Urology."

Dallas County voters approved a bond issue in a December election and plan to build a Hill-Burton Hospital at Fordyce, of 25 beds.

H. Fay H. Jones, Little Rock, attended the annual meeting of the South Central Section of the American Urological Association in San Antonio, Texas, October 17-19.

Garland D. Murphy gave the Armistice Day address for the El Dorado Lions Club last November.

Contributors to the American Medical Education Foundation from the State of Arkansas during November, 1955:

Sanford C. Monroe, Pine Bluff.

William B. Stanton, Texarkana, attended the American College of Surgeons meeting in Chicago in early November at which meeting he also was inducted into the College as a Fellow.

Gerald H. Teasley, Texarkana, spoke on Wilms Tumors at the Urological Section of the Southern Medical Association at the Houston meeting.

Charles G. Pearce is expanding the Heber Springs Hospital with a new 10-room addition.

Elmer W. Snyder is opening an office in West Memphis for the practice of general surgery.

James W. Freeland, Star City, is the first secretary of his County Society to report in full for the New Year. He sends in a 100% membership, all dues paid.

Ben N. Saltzman, Mountain Home, returned from a cruise sponsored by Duke University early in December.

Charles J. Watkins is announcing the opening of his office in Little Rock for the practice of Otolaryngology.

Gene Warren, prominent Little Rock attorney and legal counsel for the Arkansas Medical Society, addressed the Craighead-Poinsett Medical Society in Jonesboro on December 7. His subject was "Medical Quacks and Frauds."

Employ your time improving yourself by other men's documents: so shall you come easily by what others have labored hard for.—Socrates.

PROCEEDINGS OF SOCIETIES

NOTE: Secretaries of County and District Societies are invited to use this column to announce coming meetings as well as to report these meetings. Such meetings, announced in advance, will be more apt to draw visiting physicians from surrounding areas.

Washington County Medical Society elected C. S. Applegate, Springdale, president for the coming year at its December meeting in Fayetteville. Other officers elected were Preston L. Hathcock, Fayetteville, vice-president; W. J. Butt, Fayetteville, secretary-treasurer.

New officers recently elected by the Faulkner County Medical Society are: President, John W. Sneed, Jr., and Secretary, Charles A. Archer, Jr. Both are from Conway. B. F. Bannister, Conway, was named Chief of Staff of Memorial Hospital at the same meeting.

The following Arkansas Pathologists were registered at the meeting of the College of American Pathologists and the American Society of Clinical Pathologists in Chicago on October 9: They were K. R. Duzan, El Dorado; R. H. Chappel, Texarkana; William Orr, Little Rock; Philip Pemberton, Pine Bluff; and A. S. Koenig, Fort Smith.

Mrs. Koenig retired as the second vice-president of the Women's Auxiliary of the American Society of Clinical Pathologists, and was elected secretary-treasurer of the Auxiliary for the year 1955-1956.

Plans are being made for an Alumni Association meeting to be held in Chicago in June, 1956, at the A.M.A. meeting there. Watch for further announcements.

AMERICAN ACADEMY OF ALLERGY

St. Louis

February 6, 7, 8, 1956

No Registration Fee

Guests Are Invited

PLAN NOW TO ATTEND!

James G. Stuckey of Little Rock was the guest speaker at a meeting of the Pope-Yell County Medical Society held November 10th at St. Mary's Hospital in Russellville.

W. E. King, Secretary-Treasurer.

CONGRATULATIONS, BOB!

R. B. Robins celebrated the completion of 27 years of service as secretary of the Ouachita County Medical Society by giving a dinner for the members of that Society on Thursday, December 8th, at the Camden Country Club.

Euclid Smith, Hot Springs, gave a talk on "Chronic Rheumatoid Arthritis" and L. H. McDaniel, president of the Arkansas Medical Society, spoke to the group on "The Heart of Medicine."

Joe A. Norton, Little Rock, reviewed the preliminary plans for the coming state meeting and spoke of the nation-wide television broadcast of the meeting which will be held on Monday night, April 23rd, as part of the Ciba Pharmaceutical Company's series "Medical Horizons."

The members of the Ouachita County Society presented Dr. Robins with a billfold in appreciation of his efforts in their behalf and telegrams from local business concerns congratulating him were read during the meeting.

E. L. Hutchison has been elected president of the Jefferson County Medical Society. Other officers are J. S. Spillyards, vice president, and Howard Stern and Charles W. Reid, delegates to the State Medical Society. Harold Morris and Calvin Simmons are alternates. Charles W. Anderson has been elected chief of staff of Davis Hospital. Other new staff officers are Frank Reed and J. S. Robinette.

FIVE COUNTY

Members of the Five County Medical Society, comprising Sevier, Polk, Pike, Little River, and Howard counties, met in DeQueen Friday night, December 9. Following dinner an informative discussion on "Diagnostic Procedures in Office Gynecology" was presented by J. W. Harrison assisted by Walter Barnes, both of Texarkana. Joe Norton of Little Rock was a guest.

Wayne G. Pullen, Secretary.

ANNUAL MEETING

Institute in Psychiatry and Neurology

March 1 and 2, 1956

The Eighth Annual Institute in Psychiatry and Neurology will be held at the Veterans Administration Hospital, North Little Rock, Arkansas, on March 1 and 2, 1956. Participants will include the following: Walter E. Barton, superintendent, Bos-

ton State Hospital, Boston, Massachusetts; J. B. Bounds, manager, Veterans Administration Hospital, Jefferson Barracks, Missouri; J. F. Casey, director, Psychiatry and Neurology Service, Veterans Administration Central Office, Washington, D. C.; Ralph M. Chambers, formerly chief inspector, Central Inspection Board, American Psychiatric Association, Washington, D. C.; Henry A. Davidson, Essex County Hospital, Cedar Grove, New Jersey; R. H. Felix, director, National Institute of Mental Health, Bethesda, Maryland; R. Finley Gayle, Jr., president, American Psychiatric Association, Richmond, Virginia; R. W. Gerard, The Neuropsychiatric Institute, University Hospital, Ann Arbor, Michigan; Francis J. Gerty, professor of Psychiatry, University of Illinois College of Medicine, Chicago, Illinois; Granville Jones, superintendent, Eastern State Hospital, Williamsburg, Virginia; A. Lowell Kelley, professor of Psychology, University of Michigan, Ann Arbor; Lawrence C. Kolb, director, Psychiatric Institute, New York, New York; F. Douglas Lawrason, provost for Medical Affairs, University of Arkansas School of Medicine, Little Rock; Theodore Lidz, professor of Psychiatry, Yale University School of Medicine, New Haven, Connecticut; Karl A. Menninger, The Menninger Foundation, Topeka, Kansas; Miss Mary Redmond, director, Psychiatric-Mental Health Nursing Program, Catholic University, Washington, D. C.; R. Finley Gayle, Jr., will be the principal speaker at the dinner session Thursday evening, March 1st. On Wednesday, February 29th, preceding the institute proper, there will be seminars in clinical psychology and psychiatric nursing.

CRAIGHEAD—JONESBORO

We had our Annual Barbecue December 7 at the Elks Club in Jonesboro. Had barbecued pork, beef and coon.

The following officers were elected for 1956: President, Grover D. Poole, Jonesboro; Vice-President, James W. Webb, Jonesboro; Secretary, J. H. McCurry, Cash.

Censor for three years to succeed John T. Gray, Horace C. Barnett, Jonesboro.

J. H. McCurry.

WOMAN'S AUXILIARY

Mrs. Mason G. Lawson of Little Rock, president of the Woman's Auxiliary to the American Medical Association, was the speaker at the December meeting of the Pulaski County Medical Society. She also attended the Interim Session of the A.M.A. in Boston, earlier in the month.

A Combined Neuro-Effector and Ganglion Inhibitor

Pro-Banthine consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

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In Roback and Beal's² series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

Pro-Banthine (β -diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

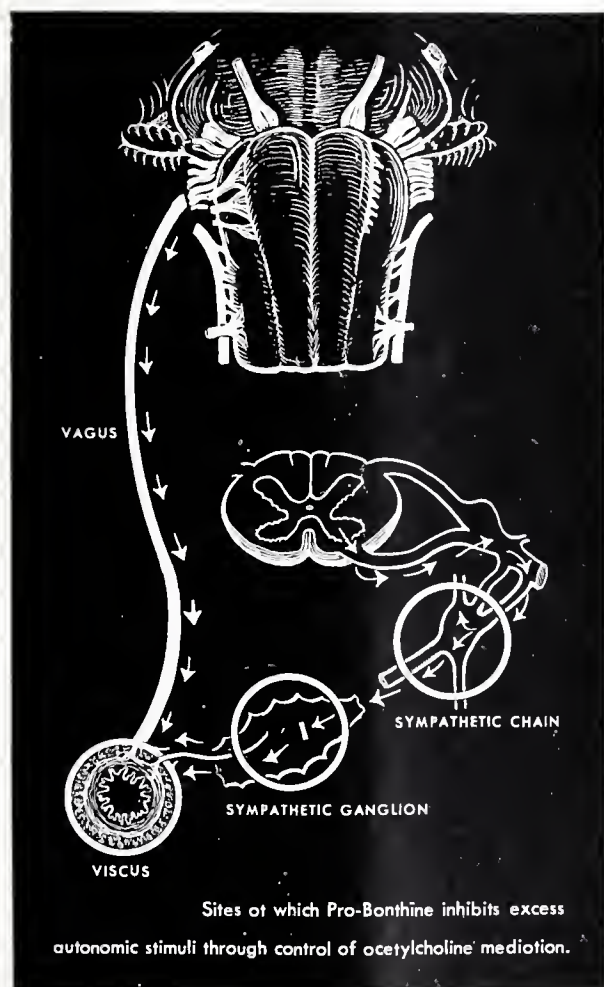
1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: *Gastroenterology* 25:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: *Gastroenterology* 25:24 (Sept.) 1953.

Clinical trial packages of Pro-Banthine and the new booklet, "Case Histories of Anticholinergic Action," are available on request to . . .

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BOOK REVIEWS

Cancer Cells: E. V. Cowdry, Director, Wernse Cancer Research Laboratory, Washington University, St. Louis; formerly President, American Association for Cancer Research and Fourth International Cancer Research Congress. President, American Gerontological Society and Second International Gerontological Congress. Cloth. Pp. 677. W. B. Saunders Company, Philadelphia and London, 1955.

This very excellent monograph is an attempt on the part of the author to summarize in one volume all of the known facts about cancer cells. This includes not only the properties of malignant cells but malignant potentialities of normal cells and a discussion of the various carcinogenic agents which bring about malignant transformation in normal cells. The discussion of the carcinogens not only includes previously known carcinogenic agents, but also includes a discussion of viruses and steroid hormones. Heredity is also discussed quite extensively in relationship to cancer. There is a large section devoted to geographical occurrence and cancer prevention with additional information on cancer diagnosis and treatment. The final chapter is devoted to cancer research with a discussion of the types of research and lines of investigation conducted at the present time. A very excellent appendix contains a listing of all of the various cancer journals and registries of tumor pathology.

This volume represents a valuable reference in the field of cancer principally for the research worker, but will probably be of little value to the general practitioner or clinician not primarily interested in cancer work.

—A. S. KOENIG.

Basic Surgical Skills: Robert Tauber, M. D., F.A.C.S., Asst. Prof. of Gynecology and Obstetrics, Graduate School of Medicine, Univ. of Pennsylvania. Illustrated. Pp. 75. \$3.75. W. B. Saunders Co., Philadelphia.

This short monograph presents a training schedule that should be followed, and practiced by the developing surgeon.

The Slow Square Knot tying is first described, then the Fast Square Knot, Square Knot with Instruments, the Suture Ligature, different types of stitches, Continuous Suture, Prophylactic Hemostasis and Replacement of Hemostats is discussed in that order.

All procedures are excellently illustrated with step by step diagrams, and several useful instruments are described, e.g. a knotholder, the bridge clamp, a ligature carrier and hook, and needle forceps.—V. O. LESH.

Preventive Medicine in World War II: Environmental Hygiene, Vol. II: Editor-in-Chief John Boyd Coates, Jr., Col. M.C., U. S. Army. Pp. 404. Illustrated. U. S. Government Printing Office, Washington, D. C. \$3.50.

This is a ready, readable source on the modus operandi of disease control as practiced by the Army in all theatres of engagement during World War II. The obstacles are listed, and a proper method of overcoming these obstacles is given. Plans are demonstrated how an area can be made habitable, and even healthful for troops, and civilians

through insect control, rodent control, and complete sanitary control of such an area. There is a wealth of material for any physician—either in the city or country to which he can refer for assistance in the environmental control of disease.

The book has a practical approach, and contains valuable information for health officers and any medical man interested in sanitation. There is scarcely a practitioner of medicine who would not find this book helpful.

Surgery in World War II: Hand Surgery Edited by Sterling Bunnell, M.D., San Francisco, Civilian Consultant for Hand Surgery to the Secretary of War. Pp. 447. Illustrated. Buckram. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. \$3.75.

One of a series of volumes of the Medical Department of the U. S. Army is presented. This number deals in the history of the treatments of hand injuries and its development and refinement. The military aspects are everywhere in evidence but the text is a reference work of considerable value and in case of future hostilities can be used as a text on a similar subject. There is no wealth of clinical material, but there is sufficient to make the effort of reading the book a pleasant one. Some few quotations are made from army directives as the handling of this type of injury evolved. If brain surgery made its greatest step in World War I, then hand surgery improved materially in World War II.



.....The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

FEBRUARY, 1956

No. 9

WHAT IS MAN THAT MAN SHOULD BE MINDFUL OF HIM?

A REVIEW OF SERVICE TO MANKIND

By HARDY A. KEMP, M.D.*

Fellow of the American College of Preventive Medicine

Professor of Preventive Medicine

Service to mankind is one of the most human of all our deeds and thoughts. It has always been so, for the basis of man's essential nobility is his inborn longing to serve some one or some thing, and to be responsible for that some one or that some thing.

Put to practice these longings find expression in our attempt to get people out of trouble, in our efforts to understand and to mold faulty character, indeed in our prayers to make ourselves and the world better. These pressures are age-old. They have been a part of us since the beginning of time. So natural to us are they that we give them no more inquiring thought than we allow to the philosophical reasons for the rhythms of our hearts. Yet we would do well to inquire. We would do well to review these deeper motivations and to test the essence of their nobility.

Thus, a little over 45 years ago Sir William Osler—still our modern—day patron saint of medicine—memorialized Robert Koch's discovery of the tubercle bacillus in a presidential address to the Conference of the National Association for the Prevention of Consumption and Other Forms of Tuberculosis. This was held at the University of Edinburgh, on a Sunday afternoon, July 3, 1910, only a few months after the death of the great German bacteriologist. To those assembled, Osler pointed out that "To man there has been published a triple gospel: of his soul, of his goods, and of his body. Preached and professed in a hundred different ways, throughout the years these gospels have grown with man and as such they represent the ever-widening and unceasing purpose of his thoughts."

Osler pointedly remarked that the gospel of man's soul has sometimes brought hope, too often

despair, and that the wise men of the Orient, Confucius, particularly knew what a heavy yoke religion might be. Yet that need not be so. There is today the witness of twenty centuries of the gospel of One whose yoke is easy and whose burden is light. That gospel has grown to be the earnest desire of the better portion of the human race.

As for the second gospel, that of man's goods, Osler dismissed it sharply saying that it has been written in blood on every page of history.

The third gospel, he said, the gospel of man's body, brings man into relation with nature. Indeed it is the final conquest of nature out of which has come as Osler phrases it, man's redemption of man; for all along, throughout the ages, the history of man is a story of a great martyrdom—plague, pestilences, famine, wars, murders, tortures inconceivable until man's inhumanity to man has outdone the apparent atrocities of nature. It is perhaps the most staggering concept with which thinking man must deal. A great church-man of our times, Cardinal Newman, has asked of this great mystery, "Which of us in the millions now living can weigh and measure the aggregate of pain and suffering of only a single generation?" Then he tells us that when we add to that all the pain which has fallen and will fall upon the race of men we may indeed cry out with the Psalmist, "What is man that Thou are mindful of him?"

The Psalmist will also have it no man may redeem is his brother saying, "They that trust in their wealth and boast themselves in the multitude of their riches, none of them can by any means redeem his brother, nor give to God a ransom for him." Here, however, the Singer speaks of the soul, "For the redemption of the soul is precious," and only God may redeem the soul from the power of the grave. Nevertheless, man being

* From the Department of Public Health and Preventive Medicine, Baylor University College of Medicine, Texas Medical Center, Houston, Texas.

man "abideth not: he is like the beasts that perish."

From this gospel of man's body and from all the ages in between there has emerged man's redemption of man here on earth, and from this we pause to ask, "What is man that man is mindful of him?" What sustains and advances man's medical services to mankind, the service that brings this redemption? Who brings it, and what is its price?

It is brought and bought by the lives of those who many times give their own lives to keep alive the altar-fires of science. It is paid for by those who open the doors of knowledge so that we may know the laws of health and disease. Who are they, these redeemers of our bodies? Their names are not all nor always, "Jonas Salk," "Sir Frederick Banting," "Louis Pasteur," "Robert Koch," "Walter Reed." Oppositely, they are the silent workers, often unknown and neglected by their own generation, but whose quiet and devoted efforts have within the memory of many of us here worked miracles upon the earth, things of which the prophet Isaiah foretold in centuries past, "And man shall be as an hiding place from the wind, a covert from the tempest as the shadow of a great rock in a weary land . . . and there shall be no more thence an infant of days, nor an old man that hath not fulfilled his years." These modern-day miracles are the wonders prophesied by the twenty-six healing miracles of Our Lord, the Master Physician, who raised the dead, made the blind to see, cleansed the leper, and made the lame to walk. St. John saw a glimpse of it in the new heaven and the new earth, when former things should pass away and there should be no more crying and no more sorrow. More particularly we are reminded that 109 years ago almost to the day, for the day was October 16, 1846, part of that prophesy was fulfilled — "Neither shall there be any more pain." A mystery of the ages was solved that day in the amphitheater of the Massachusetts General Hospital by a daring experiment performed upon a man by a man. It was the introduction of anesthesia, and so moved was the distinguished physician-poet, Weir Mitchell, that he wrote,

"Whatever triumphs still shall hold the mind,
Whatever gifts shall yet enrich mankind,
Ah, here, no hour shall strike through all the years,
No hour so sweet when hope, and doubt and fears
Mid deepening silence watched one eager brain
With God-like will decree the Death of Pain."

Today we take this all for granted, but how long the road, how great the task which first gave the chemical elements and then brought the brave hearts that had to risk conscience and reputation,

even life itself in an experiment the issue of which was deeply held in doubt? What **is** man that man should be mindful of him?

Even wider in its benediction since it embraces all races and classes of men in our modern world has been the conquering march of Sanitary Science against pestilential disease. Man's mindfulness of man is no where so well exemplified as in the near-abolition of the acute infections, the fevers, and the contagions. It is not too much to say that the near-abolition of small pox, typhus, and typhoid fever has changed not only the structure of our medical practice but the very structure of society itself. A blundering art fifty years ago, preventive medicine has become a science which takes its origin from the discovery of the causes of epidemic disease. It is in this conquering of the plagues that man's redemption of man, man's mindfulness of man has shaped our present and will shape our future. Yet our heaviest responsibility today is to make available to all mankind that which has redeemed the human bodies of the western world, for what **is** man that man should be mindful of him? What is it but the unending fight against the forces of evil?

The fight goes on. Tuberculosis was and still is one of the great infections of the world. One of the greater triumphs of the past generation, one of the greater advances in man's redemption of man was the discovery of its cause. Equally triumphant is today's successes in its control through methods of human engineering, not through skilled treatment alone. In this newer triumph we exult to find a tone in human sentiment the ancients never heard, a tone our fathers heard but faintly, not knowing its significance, or yet recognizing it. We know it today as the brotherhood of man brought forth by the socialism of science which, above all, is not the socialism of Marx and Lenin. Nor should we fear to weigh the world in this new balance lest we drain the strong sap of its life so long as we materialize in the service of man those eternal principles upon which life rests: morality, liberty, and justice — "The righteousness that exalteth a nation." For the first time in modern history the ultimate triumph of these ideals is being brought into question, and unless we eagerly strive to uphold them, they will be replaced by others we abhor. What, then, is man that man should be mindful of him, and how **can** man be mindful?

Only through a philosophy that is fundamentally religious. A modern philosopher tells us that religion is the hunger of the soul for the impossible, the unattainable, the inconceivable; yet who can doubt that beyond each of us there lies

a larger power, friendly to us and our ideals? These values we crave can be gained only if we admit the presence of spiritual realities in man's universe; for man's tremendous capacity for dedication to something greater than himself must of necessity draw upon a power greater than he can command. Thus, as Gordon Allport points out, man's religion becomes the audacious effort, the audacious bid he makes to bind himself to creation and to the Creator.

Those whose names stand high on the list of men who have striven to redeem the bodies of men know this connection is real. Florence Nightingale never doubted it for the slightest moment. From it she drew her boundless energy, her brilliance, her commanding personality that brought generals and statesmen to be ruled by her iron hand. The gentle "Lady and the Lamp" could be and had to be at times more than a little ruthless in her mindfulness of men, the greatness of which we are only beginning to appreciate, and may never appreciate fully unless somehow we may come to comprehend the greater victory of a stupid and ill-managed war, a victory embodied by the emergence of two heroic figures, the soldier and the nurse. In each case, as one of her recent biographers has said, a transformation in public estimation took place, and in each case the transformation was due to Florence Nightingale. Never again was the British soldier to be ranked as a drunken brute, the scum of the earth. Out of the Crimea he became a symbol of courage, of loyalty, and of endurance, not a disgrace but a source of pride. Never again would the picture

of the nurse be that of a tipsy, promiscuous haridan. Florence Nightingale stamped the profession of nursing with her own image, and the nurse who emerged from the Crimea, strong and full of pity, controlled in the face of suffering, unself-seeking, superior to the considerations of class or sex was Florence Nightingale herself. In the midst of all the muddle of war, the filth and the suffering, the agony and the defeats, she brought about a revolution that marked for all time a shining example of man's mindfulness of man, man's redemption of man, but a redemption more by the spirit, less by a conquest of nature and its secrets.

Elizabeth Barrett Browning sang,

"A poor man served by thee shall make thee rich;
A sick man helped by thee shall make thee strong;
Thou shalt be served thyself by every sense
Of service which thou renderest."

Fifty years ago Warbasse taught us, "If there is any joy which man should prize, it is the joy of relieving distress. There is but one greater, and that is the joy of preventing distress. The life of the physician is spent in the midst of both of these, and he should be the most blessed of men."

Thus, to us there is published a newer gospel, a new appreciation for the dignity of man and the value of human life. And how are we to assess this enormous gain, this new criterion? The teachings of all the ages tell us that that which benefits human life is God. We need only look to see in this new gospel a link between us and the Master Physician — "in whose service there is perfect freedom."

WHAT'S NEW IN NEUROLOGY

By WILLIAM K. JORDAN, M.D.

Department of Neurology, School of Medicine, University of Arkansas

Twenty years ago, the physician confronted with the problem of treating a patient with a medical neurologic disorder was justified in assuming an attitude of therapeutic pessimism. In the intervening years, the situation has undergone a remarkable change. For instance, infections of the nervous system such as meningococcal meningitis, and even tuberculous meningitis, can be treated now with much success by chemotherapy and antibiotics. The use of penicillin has reduced the incidence of neurosyphilis and, when it does occur, is very effective in arresting the progress of this affection of the nervous system. The Salk

vaccine gives promise of preventing poliomyelitis in 60 to 90% of individuals and is a major advance in control of the virus infections of the nervous system.

These advances have come to neurology from other fields of medicine. Within neurology itself, contributions have been made, particularly in the control of the convulsive disorders. In 80% of the patients suffering from one of the forms of epilepsy, seizures can be satisfactorily controlled by use of appropriate chemical therapy.

In addition to this therapeutic progress, our understanding of the underlying mechanisms of neu-

rologic disorders has gone forward, as has our knowledge of the way in which the nervous system functions normally. These advances, as well as those made in therapeutics, have recently been summarized for the general practitioner.^{1,2}

In the present review several new observations pertinent to vascular diseases of the brain and to our newer knowledge of the pathological chemistry and therapy of one of the degenerative diseases of the nervous system, namely hepatolenticular degeneration, will be described. These studies are offered as examples of the progress being made in our understanding of two important classes of neurologic disorders in which it is usually considered that little or no improvement in our knowledge is being made.

Vascular Disease of the Brain

At present, treatment of cerebrovascular disease, once it has developed, is not satisfactory. Hence, any information that opens up avenues for its prevention is useful. A report has appeared recently which may well have important implications for prevention of this common disorder of the nervous system, as well as for its therapy.

Wilson and his associates³ in Philadelphia studied a series of 542 patients in whom evidence of an acute cerebrovascular accident was found at autopsy. The medical history, clinical examination or autopsy gave evidence of cardiocirculatory insufficiency in 83 per cent of these patients. These authors believe that their findings indicate that systemic circulatory inadequacy plays an important part in the causation of cerebrovascular accidents, and that preventive measures and therapy should be oriented toward maintaining and restoring general circulatory efficiency to as great a degree as possible. Their experience with stellate-ganglion block has not been as favorable as that of others, and they point out that a number of patients with cerebrovascular accidents show a gratifying degree of spontaneous recovery, and that, therefore, evaluation of results of therapy is difficult in this disorder. They remark that it is possible that some of the effects of stellate-ganglion block may be the result of improvement of systemic circulatory efficiency, since improvement after block has been reported in paroxysmal atrial tachycardia and atrial fibrillation. They do not consider the condition of the general cardiocirculatory state to be the sole factor, but rather one of the more important factors, in the etiology of cerebrovascular disease.

Cerebral angiography has made possible a clear understanding of the syndrome of partial or complete occlusion of the internal carotid artery. The importance of this disorder was emphasized

in 1899 by Gowers and in 1914 by Hunt. Egas Moniz and his collaborators, in 1937, were the first to describe cases of this condition diagnosed by arteriography. Its frequency is indicated by an incidence of 1 per cent in all arteriograms performed in Egas Moniz's clinic. Thrombosis of the internal carotid artery can occur from the second decade to the seventh; the highest incidence appears to be in the fifth and sixth decades. Etiologically, it is most often related to arteriosclerosis and occasionally to thromboangiitis obliterans. The two commonest sites of thrombosis are near the point of origin of the internal carotid artery and in the intracranial portion of this vessel close to its termination at the circle of Willis. Denny-Brown⁴ has pointed out that this disorder should be considered in patients with recurrent neurologic symptoms apparently related to vascular disease of the brain. Numbness of the face or extremities, weakness or paralysis of the face, arm or leg and aphasia persisting for a short time and followed by improvement, perhaps with complete remission, are characteristic symptoms. Blindness may or may not occur. Arterial pulsations in the neck may appear to be full and normal on both sides. Denny-Brown has suggested that many of the cases of transient neurologic symptoms attributed to spasm of cerebral vessels are due to insufficiency of the carotid or basilar artery. He has also called attention to the fact that recurrent symptoms referable to the nervous system can occur on the basis of partial occlusion of the basilar artery, especially in its lower third. Symptoms of basilar involvement include attacks of mental confusion, blindness or unconsciousness, with residual bulbar dysarthria.

Arteriography is the principal means of demonstrating thrombosis of the internal carotid artery. If cerebral vessels are viewed after the injection of the dye, normal or increased circulation in the external carotid branches may be seen, and the branches of the internal carotid artery are invisible. Occasionally, the lumen of the part of the artery that lies within the sinus, or beyond it, is seen to be narrowed, irregular and abnormally straight, and flow through the anterior and middle cerebral arteries is decreased or blocked. Sometimes, the stump of the internal carotid artery, about 2cm. or less in length, may be seen in the film of the neck when the occlusion occurs close to the common carotid artery. Denny-Brown has also urged caution in the use of arteriography in elderly patients, because of the danger of producing thrombosis in extremely atheromatous vessels. He has described two clinical tests that may be of value in diagnosis of this disturbance. Observation of the fundus on the side of

the suspected lesion while the opposite carotid artery is compressed or while light pressure on the globe of the eye is exerted with the finger discloses narrowing of retinal vessels, if they derive their circulation from the opposite carotid artery. He states that these tests are positive in only about half the cases, probably because of the presence of external carotid collaterals. Compression of the carotid artery on the side of the symptoms will also reproduce the symptoms in about half the cases. Denny-Brown regards a history of repeated episodes of paralysis in the same limb as the most characteristic feature of the syndrome.

Progress in vascular surgery has been such as to make it feasible to remove the partially occluded region of the internal carotid and anastomose the ends of the carotid or insert an arterial transplant or plastic tube in place of the diseased section of the artery. This possibility is now being considered in a number of neurosurgical clinics.

Hepatolenticular Degeneration

Hepatolenticular degeneration (Wilson's Disease) is a familial disorder characterized by signs and symptoms of disturbed function of the extrapyramidal system and accompanied by cirrhosis of the liver. In many patients there is present a peculiar greenish brown pigmentation of the cornea near the scleral juncture, the Kayser-Fleischer ring. The neurological manifestations are varied, but usually they consist of tremors and rigidity. The tremor may be of the wing beating type. This is a peculiar abnormal movement of the upper extremities, usually absent when the arms are at rest but developing after a quiet period when the arms are held extended, and consisting in an up and down movement of the hand or of the entire arm. In some patients there is an intention tremor on finger to nose movements, and in others there is a parkinsonian type of tremor. The rigidities are of the cogwheel or lead pipe varieties. The course of the disease has been invariably downhill, terminating in death of the patient within a few months or years.

The presence of two metabolic errors in hepatolenticular degeneration has been firmly established. In the first place, Cumings⁵ has fully confirmed earlier reports describing abnormal accumulations of tissue copper and an excessive excretion of copper in the urine of patients with this disease. Secondly, increased urinary excretion of amino acids, in the absence of hepatic failure, has been demonstrated in this disorder by Uzman and Denny-Brown.⁶ A rise in urinary excretion of the ten "essential" amino acids and also of the

"non-essential" acids, glycine and alanine, has been shown to occur in the absence of an elevated serum amino nitrogen. It has been suggested that the abnormality of amino acid excretion is secondary to a failure of reabsorption of the amino acids by the renal tubules.

Serum copper values have been described as abnormally high in cases reported by Glazebrook,⁷ although not all patients demonstrated an elevation of serum copper. Serum copper is almost entirely in the form of a metalloprotein complex, which Holmberg and Laurell have shown to be a single pure protein, called by them caeruloplasmin. This protein is blue globulin of molecular weight of about 151,000, each molecule containing 8 atoms of copper. Electrophoretic analysis has shown that it is an alpha globulin. Scheinberg and Gitlin⁸ have observed that patients with hepatolenticular degeneration have much less caeruloplasmin in their serum than normal subjects, despite the fact that their serum levels may be either higher or lower than normal; the caeruloplasmin content of the serum of patients with this disorder is consistently too low to account for the total amount of copper present in the serum.

It has been suggested by Himsworth⁹ and by Uzman and Hood¹⁰ that the cirrhosis observed in hepatolenticular degeneration is the direct consequence of the chronic loss of amino acids, in accordance with the observation of the high incidence of hepatic involvement by itself in families in which one or more members are affected, as well as in the Fanconi syndrome, which is also characterized by a generalized aminoaciduria.

Denny-Brown and Porter¹¹ and Cumings,¹² as well as others, have reported clinical improvement after the administration of BAL. Varying dosage schedules have been employed, and courses of therapy have usually been repeated. Fading of the Kayser-Fleischer ring has also been reported by Denny-Brown. He suggests that the development of severe forms of the disease may be prevented by detection early in its course and treatment with BAL at this stage. Uzman and Hood¹⁰ report that 5 of the asymptomatic members of a family in which 4 siblings died as a result of hepatolenticular degeneration had persistent amino acid in the urine. With laboratory procedure capable of demonstrating the biochemical defects characteristic of this disease, despite the absence of overt clinical symptoms, and with a form of therapy that holds out hopes of forestalling the development of serious symptoms, a more optimistic approach may be taken to this hitherto untreatable neurologic disorder.

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CRITICISM OF PHYSICIANS: BY JUDGES

E. H. CRAWFIS, Little Rock *

The problem of overcrowding in State Hospitals is not a new one. It has existed for many years and will very likely continue. Here in Arkansas, the State Hospital was filled to capacity within half a year after its opening about seventy-five years ago, and has been badly overcrowded ever since. The essential problem, of course, is that there is a significantly greater need for mental hospital beds than the State of Arkansas has been able to provide. At the present time our rated bed capacity by the State Board of Health standards is 3,664 beds. On June 14, 1955, our census was 5,083, with an overcrowding of 38.73 per cent. To accommodate this number of patients it is necessary to put down mattresses and sleep 165 patients on the floor, in hallways. Most of our dormitories have beds crowded together as closely as possible.

Our overcrowding forces us to resist admission to the hospital in many cases, even though we recognize the need for hospitalization. The number of patients who are presented to us for hospitalization is much greater than our ability to admit and treat, or even to provide a bed for them.

In an effort to limit our admissions, a letter was sent to all Probate Judges and Sheriffs in Arkansas in February, 1955. This letter presented the facts on our overcrowding and asked the Sheriffs

to check with the hospital as to whether a bed was available, before bringing a patient to the hospital for admission. As a result of this letter, I have had conversations and correspondence with several of the Probate Judges in various parts of the state. They were critical of local physicians in regard to the commitment of patients to the State Hospital. It seemed to me that it would be worthwhile to bring this information to the attention of the physicians of Arkansas, in an effort to improve the relationship between the legal and medical professions.

The Probate Judges feel that they are bound by the evidence presented in a physician's certificate. When a physician certifies to the Court that a person is mentally ill and in need of confinement, the Judge must issue a commitment. Here is a direct quotation from one Judge's letter:

"Judges are, of course, not physicians and few if any of us would undertake to debate the question of sanity with a physician. Although I have personally often felt that physicians were certifying facts to my court which they knew were not true, I would have an unmitigated gall to act upon such a feeling officially and decline to follow their certifications. Who am I to hold officially that a highly respected doctor is either incompetent or a liar? I will not scandalize either the legal or the medical profession by any such rating."

There were a number of instances cited by the Judges to support their strong feelings. The category most frequently mentioned involves the

* Received for Publication July 1, 1955, from the Arkansas State Hospital for Nervous Diseases.

commitment of elderly individuals. I have received a number of such stories. Again I would like to quote from a Judge's letter:

"An old lady wanted to commit her husband to the State Hospital. The husband is old, poor, and sick. Numerous people who know him well told me he was normal mentally but terribly poor and ill. Nevertheless, two doctors had certified to me that he was insane. I just couldn't take it. I don't want to be a party to making a "poor house" out of our State Hospital. I refused to hear it officially because I would not make a record of disbelieving a doctor under oath."

Another category of concern to the Judges is that of the alcoholics. Several of them expressed the idea that physicians certified patients to the State Hospital after severe alcoholic episodes, and that thereby the individual was able to escape punishment for criminal acts committed while drunk.

Act 241 of the 1943 Legislature provides for a simple and liberal admission procedure to the State Hospital. We may admit any person suffering from an acute psychosis who requires immediate hospitalization, upon the written request and certificate of any Health Officer, or regularly licensed and practicing physician. Note that only one physician's statement is needed for this type of admission, as opposed to two for Court commitment. It also eliminates the necessity for the court appearance for the physician and the patient. The patient may be taken to the hospital by his relatives or friends, rather than by the Sheriff or his deputies.

The intent of the statute was to limit the Probate Court commitment procedure to those persons who were "dangerous." However, a number of the Probate Judges have informed me that the physicians in their area either have no understanding or no sympathy with these provisions of the law.

These physicians take the position that a Court commitment is necessary in every case. This clearly was not intended by the Legislature, and is not consistent with sound medical philosophy.

A sick person should not be subjected to the psychic trauma of Court procedure unless it is absolutely necessary. The Probate Judges frequently do not require the patient's presence in the court for the hearing on commitment. They feel that it is desirable to avoid disturbing the patient by court appearance. On the other hand, court procedure tends to become routinized and the majority of cases do require the presence of both the patient and the physician.

Such medical certificate admissions account for approximately 50% of our admissions. Voluntary admissions account for about 10% of our admissions. Unfortunately, Probate Court commitments still account for approximately 30% of our admissions. Our staff is in unanimous agreement that many of the patients committed in this way are not dangerous, and that their Court appearance represented unnecessary psychic trauma.

Another practice which is condemned by the Judges is pure and unadulterated perjury. When one physician has examined an individual and pronounced him insane, another doctor who has never so much as laid eyes on the patient will also sign another certificate to the same effect. This is a dangerous practice and cannot be defended or justified on any grounds. Again it should be pointed out that the admission by medical certificate eliminates this dangerous practice.

I would like to emphasize that these criticisms are not raised in any vindictive manner. I can illustrate this best by again making a direct quotation:

"I will not believe that the physicians of Arkansas really understand the true nature of what they are doing to our Courts and to our State Hospital. But they certainly need to be awakened. I appeal to you, Dr. Crawfis, to deal with this situation as a member of the profession, yourself. Surely one of the most ancient and respected of the professions will not compel Courts of law to hold their members to be perjurers or lacking in a sense of community obligation."

I am convinced that the medical profession can accept such criticism and correct such practices where they exist. The fact that nearly half of our admissions come to us on the basis of medical certificates indicates a large number of them are enlightened and that the criticisms voiced apply to a minority. Therefore, I am presenting these criticisms to our profession in the hope that cognizance will be taken of them. I believe that it would materially improve the relationships between the legal and medical professions if practicing physicians would take the time to discuss this problem with the Chancellor of their respective District.

<p>MEDICAL EDUCATION WEEK April 23-29, 1956</p>

— ★ Editorial ★ —

LETTER TO OUR SENATORS

Dear Senator: House Bill 7225, extending government relief and its tax to more people is to come before the Senate in February.

Arkansas physicians hope for active opposition to the bill because of its step to a government-controlled profession. We are asking that you support us in this opposition.

"Social Security" so called, has been a parade of step-by-step changes in our form of government to a "statism" or pure socialism. (And the purest Socialism is Communism). This "security" has been sold to the public on a something-for-nothing basis, as a bargain. As such, it is a moral corruption, and is as ethically indefensible as any other form of gambling.

Physicians have an analogy; a great majority of Arkansas doctors recognize "Social Security" as the cancer of our government which can only grow, or die, as cancer does, and unless stopped, can destroy our Democratic way of life, as it has in Europe.

Please lend your whole-hearted effort to the defeat of this something-for-nothing bill.

INSTRUCT YOUR DELEGATES

The response of physicians to the need of money for Medical Schools in the United States has been spotty and inadequate. The record of Arkansas physicians has not been exemplary. Few have given generously and the funds received by our Medical School, has been some twenty times what we have contributed. The average of us has not been generous.

Because of this record, the American Medical Association is asking all State Societies to consider adding \$25.00 to the state dues, which monies will go directly to the American Medical Education Fund. There are no "deducts," and every penny collected will go to Medical Schools in the United States. Some states are already doing this. Such a way is fair and equitable, and to those who see the need, it will only stimulate them to more generosity. When Industry, AMEF's greatest contributor, sees generosity on the part of physicians, they will respond with greater help.

The problem may come up in April, at our annual meeting. Instruct your delegate to vote in any manner which will reflect generosity and appreciation on the Arkansas Medical Society and its membership.

THINGS TO COME

AMERICAN ACADEMY OF GENERAL PRACTICE

Washington, D. C. — March 19-23, 1956

ARKANSAS STATE MEDICAL ASSISTANTS SOCIETY

Little Rock — April 14-15, 1956

ARKANSAS MEDICAL SOCIETY

Little Rock — April 23-25, 1956

AMERICAN MEDICAL ASSOCIATION

Chicago — June 11-15, 1956

ANNOUNCEMENTS

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 34th annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 9-14, 1956, inclusive, at The Ambassador, Atlantic City, N. J.

Scientific and clinical sessions will be given September 10, 11, 12, 13, and 14. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation will award annually a \$200.00 prize for an essay on any subject relating to physical medicine and rehabilitation. The contest, while open to anyone, is primarily directed to medical students, interns, residents, graduate students in the pre-clinical sciences and graduate students in physical medicine and rehabilitation.

For information, write, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

The Twenty-ninth Annual Spring Congress for post-graduated study of the Gill Memorial Hospital of Roanoke, Virginia, is holding its session for 1956 on April 2 to April 7.

For registration blanks, write E. C. Gill, M.D., Box 1789, Roanoke, Va.

The American Goiter Association will hold its 1956 meeting at the Drake Hotel, Chicago, May 3, 4, and 5.

John C. McClintock, M.D., 149 1/2 Washington Ave., Albany, New York.

The Mid-Atlantic Section of the International College of Surgeons is holding a regional meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia, February 13-14-15. Reservations are made directly with the Greenbrier Hotel.

MEET ME IN APRIL AT LITTLE ROCK

Two additional attractions at the coming Annual Session of the Arkansas Medical Society will be a group of scientific exhibits and hobby exhibits. Those scientific exhibits listed with Chairman Lawrence Zell to date are as follows:

Titles of Exhibits	Exhibitors
"The Role of Sodium Salts and of the Acid-base Equilibrium in the Production and Treatment of Experimental and Clinical Edema"	Samuel A. Corson, Elizabeth Corson
"Problems in Vascular Surgery".....	Harwell Wilson
"Pediatric Urology"—	James O. Cooper, Schuler McKinney, Sam G. Jameson
"Arkansas Joint Committee on School Health".....	State Board of Health
"The Evolution of Fracture Treatment"—	Dr. Kenneth Jones, Dr. Horace Murphy
"Use of Electroencephalography in Practice"—	Dr. Frank Padberg
"Mental Illness and the Family Doctor".....	State Hospital
"Gout".....	Dr. Guy T. Williams
"Physician's Responsibility in Highway Accidents".....	American Medical Association
"Rhinoplasty".....	H. A. Bailey, Paul Mahoney
"Bezoars of the Stomach"—	George G. Regnier, James Morrison
"Common Congenital Anomalies of the Urinary Tract".....	Ralph A. Downs
"Management of Nasal Allergy".....	Norman N. Fein
"Dermatologic Clinic".....	Calvin Dillaha
"Hiatal Hernia in the Last Trimester of Pregnancy".....	Willis Brown, James Atkinson
"Maternity Clinic in Midwife Territory"—	William B. Harrell, J. R. Ramirez, Juan T. Mallari

A list of the Hobby Exhibits to be shown will be printed in a later Journal.

AMERICAN ACADEMY OF NEUROLOGY
Common Neurological Syndromes for
General Practitioners

A course in the more common neurological problems will be presented for General Practitioners by the American Academy of Neurology in St. Louis, Missouri, on April 25, 1956. This one-day course has been authorized by and has the wholehearted support of the American Academy of General Practice.

Diseases of the Nervous System implicated a very large segment of our population and there

has been a tremendous accumulation of literature, most of it published only in neurological journals, covering some of the newer aspects of the diagnosis and treatment. "Common Neurological Syndromes" will cover most of the problems with which the general practitioner is confronted and emphasis will be on the clinical and therapeutic aspects. The formal lectures will cover such subjects as headaches, strokes, convulsive states, the Parkinsonian state, neurological emergencies, metastatic carcinoma to the central nervous system, common disorders of muscles, peripheral nerve lesions, weakness of the lower limbs, neurosyphilis in the postpenicillin era, neurological manifestations of the blood dyscrasias, and treatment of infections of the central nervous system.

The enrollment fee for Common Neurological Syndromes is Ten Dollars (\$10.00) and application for membership should be directed to Mrs. J. C. McKinley, Executive Secretary, American Academy of Neurology, 3501 East 54th Street, Minneapolis 17, Minn.

Arkansas
TRAVELING
And Clipping Bits Here and There

Perhaps a better way to put all of this is to use the words of Dr. Harlan English of Illinois, who, when reporting the work of his committee to the AMA House of Delegates at Atlantic City last week, said that "... the only public relations program of any permanent value is the private and public relations of the individual doctor."

It is toward that goal that your Mississippi State Medical Association is working.

—The Mississippi Doctor, 1955.

FROM 535 N. DEARBORN ST.

(Editor's Note): The Council on Medical Service has presented the following recommendations, approved and adopted by the Board of Trustees.

1. That Congress be urged to consider carefully and define clearly a national policy with respect to the provision of medical care for dependents of service personnel;
2. That any program devised for the care of dependents of military personnel be made contingent on the adoption of a clear and understandable definition of what constitutes a dependent;
3. That **with respect to civilian personnel and facilities**, except in situations as outlined in

(4a) below, medical care and hospitalization of the dependents of service personnel be provided by **civilian personnel in civilian facilities**.

To develop a specific program aimed at carrying out this recommendation:

- a. It is urged that all county medical societies take such steps as are necessary to assure that medical services are available to dependents of servicemen regardless of their ability to pay;
 - b. That all county medical societies cooperate with local hospitals in assuring that hospital facilities are available to dependents of service personnel regardless of their ability to pay;
 - c. That all county medical societies participate in an organized program designed to coordinate **all** related facilities and services in the health field to the end that they will be known to and made available to dependents of service personnel; and
 - d. That all state medical associations assist their component societies in developing the above recommendations.
4. **With respect to federal programming, federal personnel, and federal facilities**, it is recommended:
- a. That the Association continue to recognize the need and importance of utilizing military medical personnel and facilities in providing hospitalization and medical care for dependents of service personnel residing outside the continental United States and its territories, and at or near military posts in the United States or its territories where civilian facilities are unavailable or inadequate;
 - b. That since the American people through voluntary insurance programs have available to them a well established mechanism to assist in meeting the costs of medical and hospital care, military personnel be urged to use this mechanism for their dependents in the same manner as do more than 99 million fellow Americans; and
 - c. That voluntary health insurance agencies be urged to promote enrollment and to assure continuation of coverage for dependents of servicemen in all areas of the United States.

And more—Dr. Lull's letter:

In view of the recent communications concerning medical care for dependents of military personnel, you undoubtedly will be interested in receiving the following information in regard to

American Medical Association policy on this subject.

The Defense Department has not contacted the Association recently regarding financing medical costs of dependents of military personnel. Although the Russell-Vinson bill is now before Congress, the Defense Department has not indicated to us what, if any, amendments might be offered and what regulations might be issued by the Secretary of Defense to implement the bill. However, the following is sent to you for your information:

1. The House of Delegates of the American Medical Association in 1954 in Miami adopted the following statement:

" . . . if it is to be the policy of the government to provide for medical care for dependents of service personnel, the services of civilian physicians and hospitals be used wherever possible, to be paid for at prevailing rates, with provision for free choice of physicians."

2. In addition, the Council on Medical Service, together with the Council on National Defense, prepared, approved, and presented to the Board of Trustees on November 27, 1954, the enclosed statement above on this subject.

/s/ George F. Lull, M.D.

THE DOCTOR BELIEVES IN ORIGINALITY

With more and more interest being stimulated within the medical profession relative to HR 7225, which would graft a cash disability benefit system on to Social Security, George C. Lincoln, 71-year-old Woodstock, Conn., physician, came up with a clever idea for fighting this proposed legislation in his own way.

In a memo to me, Dr. Lincoln said he believes that "the government is getting us, and our heirs especially, into very deep water — from which there will be no return." Attached to the memo was one of his prescription blanks. He said he sent his personal prescription blanks to the two U. S. senators of his state. On each blank he wrote this message, and signed it:

"Rx One vote against Bill HR 7225.

"Sig: Take as often as necessary to prevent economic indigestion and other dire effects should the Bill be passed.

"Prescription may be refilled and also given to friends."

RURAL HEALTH CONFERENCE SET FOR MARCH

An enthusiastic group of physicians, farm leaders and educators will gather in Portland, Oregon,

March 8-10, for the 11th National Conference on Rural Health, sponsored by AMA's Council on Rural Health. Built around the Conference theme—"Your Doctor and You"—the first panel discussion will be devoted to "The Family and Their Physician." Duane Bowler, manager of the Public Health League of Montana, Helena, will give the presentation and other resource persons will include a father, mother, 4-H boy and girl, and physician. Thursday evening's recreational program will feature music and dances by the Forceps Four, a quartet made up of medical students from the University of Oregon; the Rose Pedalers, a paraplegic group doing a square dance in wheel chairs; the Peasant Dancers of Portland, an adult community group presenting folk dances of foreign lands, and the International Folk Dancers of Oregon State College.

Other highlights of the Conference include: (1) A panel discussion on mental health with the main presentation by J. Leslie Henderson, M.D., chairman of the mental health committee of Washington State Medical Association; (2) Two panels on problems of the aged; (3) Discussions on "Uses and Abuses of Health Insurance"—main speech by Wendell Milliman, Seattle actuarial consultant; (4) Success and achievement stories. To wind up the Conference, Frank Ballard, director of the Agricultural Extension Service of Oregon State College, will give an inspirational talk titled "The Challenge We See."

Discussion leader throughout the three-day meeting will be Jack Wright, director of the Bureau of Community Development, Extension Service of the University of Washington.

From the News Advocate, Fordyce

"It is difficult to say anything against Social Security which sounds so kind and so humane, and it is not the popular thing to say, but I urge you to write your two senators to vote against the Social Security amendment of 1955, HB 7225," Dr. R. B. Robins of Camden told members of the Fordyce Rotary Club at their Wednesday noon meeting at the Kilgore Hotel.

"Talking against the extension of Social Security is somewhat like parading around a feast with a stomach pump. The fellow that does that cannot expect to be popular, the fact remains, however, that Social Security is very young. Social Security is supposed to have a surplus of 22 billion dollars in its accounts, but the money has been spent and what it has are government bonds that someone will have to ultimately pay for. You see all it has is IOUs. The Social Security System is piling up obligations faster than it has reserves

and this can only be met by higher and higher taxes as the years go by. The thing looks like a bargain to people, but is it going to be ultimately a bargain for our children and grandchildren who will have to pay the tremendous bills?" Dr. Robins said.

The Journal of the Florida Medical Association (Oct. 1955) says:

WORKING WITH OTHERS

Patients are people. The physician who thinks of them as numbers or cases or examples of some particular disease is out of tune with modern medicine. As mentioned last month in the third of this series of editorials on the practical public relations program of the Florida Medical Association, the doctor specializes primarily in people. The very nature of his profession requires him to make a business of people. Fortunately, the science of medicine and the art of medicine are so happily wedded today that the physician views his patient in the light of the total personality. He keeps his attention focused on the patient, not merely as the site of a disease, but as a human being, a member of a family and a community, beset with many problems, other than his immediate illness, which require advice and adjustment.

"The doctor is the friend, counselor and advisor to the family to whom he administers care," said Vice President Alben W. Barkley, addressing the Aero Medical Association in 1952. "I would rather have one country doctor working for me politically among my friends than anyone else. Doctors justify their profession and the confidence people give them." Unquestionably, the practice of medicine qualifies as a training school in public relations. In the school of everyday experience the physician learns how to get along with patients in particular and people in general.

RESOLUTION

WHEREAS, Arless Arland Blair died October 24, 1955.

WHEREAS, he was a graduate of the University of Tennessee Medical School in 1915, and began the practice of Internal Medicine in Fort Smith, Arkansas, in 1920. He was a member of the Sebastian County Medical Society, the Arkansas Medical Society, the American Medical Association, the American College of Physicians, in which organization he was Governor for the State of Arkansas at the time of his death. He was a Diplomate of the American Board of Internal Medicine. He was a member of the Clinical Staffs of St. Edward's Mercy Hospital, Sparks Memorial Hospital and Crawford County Memo-

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rial Hospital. He was Past President of both the Clinical and Executive Staffs of St. Edward's Mercy Hospital.

WHEREAS, in the passing of this prominent member of our Society, we have lost not only one of our outstanding citizens, but one of the most prominent Internists in the State and in the Southwest.

BE IT RESOLVED, that the Sebastian County Medical Society wishes to express its feeling of great loss in the death of Dr. Arliss Arland Blair on October 24, 1955.

BE IT FURTHER RESOLVED that a copy of these resolutions be forwarded to the family of our deceased member.

Respectfully submitted,

C. T. Chamberlain, M.D., Chairman
E. Z. Hornberger, Jr., M.D.

Adopted: Sebastian County Medical Society December 13, 1955.—J. F. Kelsey, Secretary.

RESOLUTION

The Pulaski County Medical Society in regular meeting on this the ninth day of January, 1956, wish to recognize, in a formal way, the untimely death of Paul L. Ewing, B.A., M.S., Ph.D., Associate Professor of Pharmacology in the University of Arkansas, School of Medicine.

While Doctor Ewing was not a physician, nor a member of this society, he was a member of that great body of scientific men who through untiring years of effort have diligently and quietly sought out new truths which, by their application in the practice of medicine, have decreased pain and lengthened life of mankind.

For these reasons, and others, therefore be it resolved:

1. That we, the members of this society, regret the sudden passing of Doctor Ewing in the period of full fruition of his scientific and educational endeavors and,

2. That we express appreciation for his scientific accomplishments and his contributions to the education of those who are to become our associates in the practice of medicine, and

3. That we express to surviving members of his family our sincere regret and sorrow in their deep personal loss, and

4. That this resolution be spread on the minutes of the society and that copies be sent to his

family and to the editor of the Journal of the Arkansas Medical Society for publication in that journal.

Respectfully submitted,

Jeff Banks, M.D.,

W. C. Langston, M.D.,

Chairman of Committee.

Read to Society January 9, 1956, and adopted unanimously.—G. G. Fulmer, Executive Secretary.

Obituary

B. L. BENNETT—89, Van Buren, died December 2nd at the home of his daughter, Mrs. Jesse Smith, where he resided.

Dr. Bennett was a member of the Arkansas and Crawford County Medical Societies, a graduate of the Arkansas Medical School in 1892, and a member of St. John's Methodist Church.

A physician for 60 years, he practiced medicine at Wetunka, Oklahoma, and Springdale, Arkansas, prior to moving to Van Buren. He has practiced medicine for 44 years in Crawford County.

Survivors include his wife, Minnie; two daughters, two sons, one half-brother, 13 grandchildren and two great grandchildren.

Burial was in Van Buren.

CHARLES H. WILLIAMS—78, a retired El Dorado physician, died at his home November 10th.

Born in the Marysville Community the son of George Dallas and Adeline Melton Williams, he spent his entire life in Union County.

He married Miss Mary Elizabeth Braswell, whose death occurred in 1949.

Dr. Williams was a member of the First Methodist Church and was active in affairs of the church.

Survivors include a daughter, a son, a sister and four brothers.

Funeral services were held at the First Methodist Church. Burial was in Arlington Cemetery.

C. S. EARLY—age 81, veteran Camden doctor, died in the Ouachita County Hospital November 30th after a long illness. He had practiced medicine in Camden since 1901 and was a partner of the late J. S. Rinehart for many years. He was a member of the American Medical Association and the Southern Medical Association and a past

president of the Ouachita County Medical Society.

Dr. Early was a member of the St. John's Episcopal Church of Camden.

He was born at Rockport, Ohio, on October 4, 1874, and graduated from the Ada, Ohio Literary College, and was an alumni of University of Illinois and a graduate of the Physicians and Surgeons College of Chicago. He was made an honorary member of the AMA and SMA when he retired in 1951. Dr. Early was local physician for both the Cotton Belt and Missouri Pacific railroads for many years.

He is survived by his wife, Katherine Bullock Gee Early, a daughter, and two grandchildren.

Funeral services were held December 3rd at St. John's Church. Honorary pallbearers were the members of the Ouachita County Medical Society.

WILLIAM A. BRADLEY—84, pioneer Northwest Arkansas physician, died at his home November 23rd, in Harrison.

He was born at Marshall, Arkansas, June 18, 1871, and was the son of A. A. and Mary Blair Bradley.

He was married to Cora Moss at Jasper April 12, 1896.

He graduated from Emory University, Atlanta, Georgia, class of 1895 with post-graduate work at the Universities of Arkansas and Tennessee.

Dr. Bradley was a past president of the Boone County Medical Society and a Mason.

Survivors include his wife, two sons, two daughters, ten grandchildren, and eight great grandchildren.

Burial was in Maplewood Cemetery.

Members of the Boone County Medical Society were honorary pallbearers.

WYLIE ROBERTS FELTS—Judsonia, died November 17, 1955. He was 68 years of age.

He was the son of Thomas Jefferson Felts and Almyra Felts and a native of Sharp County, Arkansas. Graduating from the University of Tennessee Medical School in 1914, he served in the American Expeditionary Force in France 1917 to 1919 and returned to Judsonia in that year.

Always active in community affairs, he was elected mayor of his home town and served in this capacity for 25 years. He was a member of

his county medical society and of the Arkansas Medical Society. He was active in the American Legion Circles.

Survivors include his widow, Mrs. Willie Lewis Felts, a son, Dr. W. R. Felts, Jr., Washington, D. C., a sister, a brother, and a grandson.

Services were held in the First Methodist Church and the remains were interred in Evergreen Cemetery.

ALVIN WEIL STRAUSS, SR.—65, died December 17 in a Little Rock hospital.

He was a member of Temple B'nai Israel, B'nai B'rith Temple Men's Club, Westridge Country Club, American Legion, Little Rock Consistory, and Scimitar Shrine.

He was a graduate of Tulane University in the class of 1912 and was a charter member of Sigma chapter of Zeta Beta Tau fraternity, a member of the staff of St. Vincent Infirmary, Arkansas Baptist Hospital and Arkansas Children's Home and Hospital. He was the first chairman of the board at McRae Sanatorium.

In professional organizations, Dr. Strauss held membership in the American Medical Association, Pulaski County Medical Association, and Arkansas Medical Society. He was a past chief of staff at St. Vincent and was an associate professor of surgery at the University of Arkansas Medical School during 1930-50.

Dr. Strauss is survived by his widow, Mrs. Tracye Altschul Strauss; a son, Dr. Alvin Strauss, Jr., Little Rock; two daughters, a sister, three grandsons and five granddaughters.

Funeral was arranged by Healey & Roth.

J. B. JAMESON—66, well known Camden physician and civic leader, died in the Ouachita County Hospital on January 2. He was stricken with a heart attack on Christmas Eve.

He went to Camden in 1919 after he had served in the Army Medical Corps during World War I, and resided there from that time until his death. He was a member of the Baptist Church and had served on the Board of Trustees for Ouachita College in Arkadelphia.

Dr. Jameson was a life-long member of the Ouachita County Medical Society and took an active role in the Arkansas Medical Society. He was a Rotarian.

Funeral services were held at the First Baptist Church.

Survivors are his wife, two sons and two grandchildren.

Interment was in Camden Memorial Park.

NEWTON J. LATIMER — Corning, age 86, practicing physician for over 65 years, died at his home on December 29 following an illness of several months.

He was born on a farm near Nashville, Tenn., on January 31, 1869, and came to Clay County in 1896. He practiced medicine in Corning for

57 years. He was an honorary member of the Arkansas Medical Association, a member of the Masonic Lodge for over 60 years, member of the Little Rock Consistory, a Shriner and a Methodist.

Surviving, other than his wife, are two sons, a daughter, and seven grandchildren.

Services were held in the Corning Methodist Church with the Reverend Byron McSpadden, pastor, officiating. Burial was in Corning Cemetery.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

REPRODUCED FOR ARKANSAS PHYSICIANS BY THE ARKANSAS TUBERCULOSIS ASSOCIATION

"A CHRISTMAS SEAL SERVICE"

THE PRESERVATION OF LUNG TISSUE IN THE TREATMENT OF PULMONARY TUBERCULOSIS

By COL. JAMES H. FORSEE, M.C.

U. S. Army Military Medicine August 1955

The surgical removal of tuberculous lung tissue in the present era of chemotherapy has revolutionized the treatment of pulmonary tuberculosis. Its use by the Armed Forces Medical Services has been so unprecedentedly good that treatment for this disease is only a temporary interruption in the career of military personnel.

The case history of patient "A," is illustrative of many which are similar. Patient "A," age 46, had his left upper lobe removed and a five-rib thoracoplasty performed in October, 1951, at Fitzsimons Army Hospital. He is well, returned to active duty in March, 1953, and has been on duty over a year. He states that he has no cough, pain or chest discomfort and maintains his normal weight. Frequent examinations give no evidence of reactivation of the disease and sputum and gastric washings are negative for *M. tuberculosis*.

He became ill in March, 1951, and in April the diagnosis of pulmonary tuberculosis was confirmed by the isolation of *M. tuberculosis* from the sputum. A 3 cm. cavity was demonstrated on roentgenographic examination. Hospitalization and streptomycin, 1 gram every third day and para-aminosalicylic acid, 12 grams daily, were started. Six months later there had been appreciable clinical improvement, a small cavity remained, and excisional surgery was done. At op-

eration, the upper lobe contained numerous smaller nodules in addition to the cavity. In the lower lobe there were scattered nodular areas. To remove the visible and palpable tuberculous disease would have resulted in the loss of the entire lung and conservation of the lower lobe seemed feasible. Decreasing the size of the hemithorax by a five-rib thoracoplasty helped to prevent over distention of the remaining lobe and probably decreased the danger of reactivation of latent lesions. No visible deformity results from upper lobectomy and a five-rib thoracoplasty.

Preserving involved lung tissue without increasing the risk of disease activation is now being achieved largely through the use of streptomycin and other chemotherapeutic agents. These agents are effective in bringing about the resolution of recently developed, exudative lesions and in localizing the lesions which do not resolve. Moreover the protracted use of these drugs favorably influences the stabilization of tuberculous lesions, increasing their suitability for surgical extirpation. The amount of lung tissue needing removal is thereby decreased. The combination of certain chemotherapy agents has virtually eliminated the development of resistance to the drugs. Their use or extended periods following surgery

has an additive effect of insuring permanency of inactivation of any remaining disease areas.

The removal of an entire lung has, in our experience, seldom been indicated. Pneumonectomy has been performed in less than five per cent of more than 900 tuberculous patients treated by excisional surgery since January 1, 1947. Usually the less involved lower lobe has been retained and only the more extensively involved upper lobe removed. Two hundred sixty-one patients were treated by lobectomy during the period 1947-1952, and in the vast majority there was appreciable disease in the remaining lung tissue on the operated side. Ninety per cent of these patients are now well, and working or able to work. Pneumonectomy has been reserved for those patients who have a severe stenosis of the main stem bronchus which is usually associated with an extensively destroyed lung.

The retention of minimally involved segments of a lobe and removal of the more involved broncho-pulmonary segments of the lobe is greatly increasing the feasibility and practice of returning military personnel to active duty after being treated for tuberculosis. This increase is shown by the fact that while during 1947-49 only 25 patients were treated by segmental resection, since January 1, 1953, 185 patients have received this form of surgical therapy. In 75 per cent of the segmental resections, the apical and posterior portions of the upper lobe were removed. Segmental resection is strongly recommended for the removal of proved or suspected lesions which are unpredictable. This is far safer than permitting them to remain.

The surgical removal of residual foci by simple wedge excision also conserves lung tissue. Lesions suitable for wedge excision are usually situated peripherally and immediately subpleural. They represent either the residual foci of previously larger areas of disease or they may have been present and unchanged for months or years. None of the patients treated by wedge excision were classified as far advanced. If *M. tuberculosis* are demonstrated in the excised tissue, the patient is treated as having active tuberculosis, including chemotherapy and bed rest. If the lesion is granuloma of non-tuberculous etiology, a protracted period of hospital care is unnecessary.

The need for the surgical extirpation of these foci, is based on several factors. An appreciable percentage of roentgenographically similar lesions are neoplastic. One cannot predict accurately whether or not the specific organisms are contained in the given lesions. We know that small lesions become larger ones and minimal disease is often the fore-runner of a far advanced

process. The meticulous study of a group of approximately 500 patients with minimal tuberculosis followed for a minimum of a five-year period revealed that 50 per cent suffered relapse. The surgical excision of these small lesions is feasible and practical and the mortality has been comparable to the removal of a diseased appendix.

There is strong evidence that the present increase in the incidence of surgical therapy will be continued and that there will be relatively few tuberculous patients who will not be benefited by proper surgery. The surgeon who successfully treats tuberculous patients properly employs the guidance of his associates and becomes a member of the tuberculosis therapy team which has replaced the one-man tuberculosis expert. In addition, the surgeon must painstakingly maintain follow-up studies for a protracted period on each patient before final assessment of treatment.

Modern military medicine effectively utilizes the tuberculous therapy team. A few hospitals have been staffed with experts in their respective fields interested in the care of tuberculous patients, including rehabilitation. With these facilities, those properly motivated are returning to duty. Most of the military personnel are able to resume active duty following hospitalization and rehabilitation.

In military service the plan of roentgenographic examination at frequent intervals, such as induction, annual physical examination, separation from the service, reenlistment, admission to hospital and prior to overseas assignments provides the opportunity for the early detection of pulmonary diseases and contributes greatly to the good results being obtained in the treatment of pulmonary tuberculosis in military personnel.

The results of a policy of conserving lung tissue in pulmonary tuberculosis have been almost phenomenal. Of 165 patients on whom follow-up studies of two and one-half years or more are available, three patients are dead; only one had active tuberculosis at the time of death. Data on two patients are inadequate. Of the remaining 160 surviving patients, 98.7 per cent are well, and working or able to work. Pulmonary tuberculosis in military personnel of the United States is now being detected early and is usually a readily manageable disease which only temporarily interrupts their careers.

**BUY
U. S. SAVINGS
BONDS**

Personal and News Items

Paul Jeffery, who has practiced medicine for forty-five years, was honored December 18, 1955, by a host of friends in his home community of Bethesda, Arkansas. More than four hundred people gathered for the occasion at the Methodist Church.

The program included a brief worship service by Reverend Mark Wimmer, Bethesda, assisted by Reverend Lloyd Conyers, of Batesville.

Mr. Jess Low, Batesville, introduced the physicians present, including J. J. Monfort, secretary of the Arkansas Medical Society, who reminisced about Dr. Jeffery's tenure in Bethesda and his pioneer days, as well as some of his experience in the more recent years, speaking of the high qualifications necessary to become as beloved, as Dr. Jeffery.

The presentation of a wrist watch was made to Dr. Jeffery by his assembled friends.

James T. Wortham, assistant dean at the University of Arkansas Medical School, took part in the program of the American Diabetic Association in Dallas the last week in January.

Pearl Waddell, Fort Smith, is now associated with the Holt-Krock Clinic.

The American Legion National Executive Committee has announced the appointment of R. B. Robins of Camden to the National Distinguished Guests Committee of the organization.

Contributors to the American Medical Education Foundation during December include Harry E. Murry of Texarkana and H. W. Thomas of Dermott.

L. H. McDaniel, Tyronza, was guest speaker at the Kiwanis Club. Ladies' Night held in Blytheville on January 6.

H. A. Stroud, Jonesboro, fractured his left hip in a fall at his home on December 22. He is recuperating at St. Bernard's Hospital.

Robert E. Richardson is now associated with Harvey Shipp in the practice of Thoracic Surgery in Little Rock.

John C. Baber, Jr., has opened offices in Little Rock for the practice of general surgery.

Gilbert O. Dean was moderator at a public meeting sponsored by the Kiwanis Club in Little Rock last month. Other participants were Edwin F. Gray, John Greutter and William S. Orr, all of Little Rock and a popular discussion on the detection of disease was presented.

Open House was held at the newly-opened Conway Clinic during the Christmas-New Year season by the physicians holding space there, Edwin L. Dunaway, Charles A. Archer, and John W. Sneed, Jr.

John E. Laman opened new offices in North Little Rock in December.

President L. H. McDaniel addressed the Rotary International Club in McGehee last month.

Guy U. Robinson is president of the Dumas Chamber of Commerce for the coming year. Besides this and numerous medical society duties, he is an alderman on the Dumas City Council.

Richard Petty, Star City, expects to be in his new offices by the latter part of February.

R. B. Robins, Camden, delivered the principal address at the Chamber of Commerce annual banquet, January 26, at Morrilton. H. E. Moblet, Morrilton, was in charge.

Lawrence Zell and Calvin Dillaha of Little Rock and D. W. Goldstein, Fort Smith, were registered at the Academy of Dermatology meeting in Chicago in December.

Gerald G. Robertson has joined the staff of the Newport Hospital and Clinic in Newport, where he will be associated with T. E. Williams, H. M. Baird, and Wayne Stanfield. He is a graduate of the University of Arkansas Medical School, and a native of Warren, Arkansas. He will do chiefly Obstetrics and Pediatrics.

Executive Secretary Paul C. Schaefer addressed the Washington County Medical Society on January 2, in Fayetteville.

Dean F. D. Lawarson has announced that a new target date has been set for the formal opening of the Medical Center. It is now March 1st.

Marriage vows of Walter S. Guinee and Miss Jacqueline Alameda Penn were pledged at St. John's Catholic Church in Hot Springs on January 2. He practices in Mountain Home where they will reside.

Vincent O. Lesh, Fayetteville, spent February 7-12 in Philadelphia doing post-graduate work at Jefferson Medical College.

Robert Lich, Jr., professor and head of the Department of Urology at the School of Medicine in Louisville, Ky., addressed the Pulaski County Medical Society on January 9.

Lamar McMillin, Little Rock, addressed the Vicksburg Historical Society, Vicksburg, Mississippi, on January 12th.

Proceedings of Societies

The Annual Arkansas-Oklahoma Regional meeting of the American College of Physicians was held in Hot Springs December 3. More than 100 attended.

Arkansans participating in the program were E. Z. Hornberger, Fort Smith; Driver Rowland, Hot Springs; Jerome Levy, Richard V. Ebert, and Daniel H. Autry, all of Little Rock.

Euclid M. Smith, Hot Springs, was in charge of arrangements for the meeting.

Donald I. Purcell, Paragould, was elected president of the Greene-Clay County Medical Society at its annual meeting. Jim Bethell, Piggott, is new vice-president, and Earl D. McKelvey was re-elected secretary. Byron Futrell, Rector, and Alfred Maddox were named delegates to the Arkansas Medical Society.

E. D. McKelvey, Secretary.

Pulaski County Medical Society named Ellery C. Gay as the president for the year 1956 at its annual meeting in December. Jerome S. Levy is new president-elect; Alfred Kahn, Jr., is vice president; R. M. Blakeley, recording treasurer; H. Ray Fulmer, recording secretary, and Mr. Gaston G. Fulmer was re-elected to the post of executive secretary.

E. L. Hutchinson, Pine Bluff, replaces Ross Maynard as president of the Jefferson County Medical Society for the coming year. J. S. Spillyard is vice-president and William K. Riley is secretary-treasurer. Delegates to the Arkansas Medical Society are: Howard Stern, and Charles Reid, both of Pine Bluff.

Benton County Medics retained the entire slate of officers for the coming year. Re-elected were: Caldeen Gunter, Siloam Springs, president; Billy V. Hall, Gravette, vice president; and Kenneth A. Siler, Siloam Springs, secretary-treasurer.

Harold Short, Beebe, was elected president of the White County Medical Society for 1956. T. A. Formby, Searcy, was elected vice-president. Hugh Edwards, Searcy, was elected secretary of the Society. Delegate to the State Medical Society will be N. C. David. His alternate is A. R. Brown, Searcy.

The Ninth Councilor District Medical Society met Dec. 16, 1955, at the Seville Hotel, Harrison, Arkansas, with 15 members present, listed as follows: D. L. Owens, Ross Fowler, H. M. Fogo, Wm. H. Breit, J. W. Dorman, C. S. Applegate, Fount Richardson, Coy Kaylor, J. D. Huskins, Jean C. Gladden, Ulys Jackson, Allen Robinson, A. R. Hammon, J. G. Gladden, Ben Saltzman. There were two preceptees from the University of Arkansas Medical School present: Bob Langston and C. D. Patterson. Also, wives of the doctors.

Following dinner Fount Richardson, president-elect of the Arkansas Medical Society, was presented and he spoke of the importance of the physician to accept his responsibility in taking an interest in legislation.

A very interesting program was presented. Gene Gladden, program chairman, introduced Oral D. Crawford, chief of anesthesia at St. John's Hospital, Springfield, gave a very interesting talk on "Advancements in Anesthesia." John Polk, a graduate of the U. of A. Medical School in 1945, chief of surgery at Mt. Vernon, Mo., spoke on "Masses of the Thorax." Coy Kaylor, Fayetteville, spoke on "Fractures of the Femur in the Adult." The program was very interesting and instructive.

James Huskins, Siloam Springs, president, was in the chair.

Stanley Applegate.

Ralph Hamilton, West Memphis, has been elected as president of the Crittenden County

Medical Society for the coming year to succeed A. C. Parker of Clarkdale.

W. J. Wright of Earle was renamed as vice president of the society and Milton Lubin of Turrell as secretary-treasurer.

The Fifth Councilor District Medical Society met January 26 in El Dorado. After a social hour at the home of D. E. White, the following program was given.

"Pathology and Diagnosis of Lymphoma," by Kenneth R. Duzan, El Dorado.

"Current Trends in Management of Leukemias and Lymphomas," by William R. Arrowsmith, New Orleans.

EDITORIALLY SPEAKING

Averell Harriman says that he is not running for president, but he is sure running for something just as hard as he can. Too, he is following the path of the modern American demagogue. At a recent conference on education in his own state he proposed that the only solution to the crisis in the public schools "is through a system of federal grants," i.e., federal aid to education.

This statement might be seemly coming from a poor state which lacked funds within its border that could be tapped for this purpose, a state that paid little into the federal treasury. When the Governor of the great State of New York, however, asks for federal aid for his schools, that is pure demagoguery.

Federal aid and federal grants come from the people, not from some monster Santa Claus who makes his headquarters in Washington. People pay federal taxes, then these monies are used to pay federal expenses and federal grants. The Governor, when he asks for federal aid for his state for a purely local problem, is confessing that he hasn't guts enough to ask his own legislators to increase taxes enough to pay the state's own personal bills; rather, he wants the federal legislators to assume the onus, tax New Yorkers, send some back to their state for their schools, and send some of it to other states on a proportional basis. New York, being the richest state in the Union, must see some of its money go elsewhere, since if it gets federal aid, the other 47 states will also.

How much of an opportunist can one become? Yet this man was elected Governor of the most populous state in the Union and has a good chance of being the Democratic candidate for the Presidency in '56. If nominated, he could be elected.

The American public is mesmerized these days with "federal grants." Hospitals, roads, farms, and many other projects receive federal grants

. . . money which grows on trees in D. C. and is passed out to all concerned at no cost to anyone. It is money that comes into being by fiat, is really quite painless to acquire, and it is the greatest of all modern day delusions.

It is also a club. The bureaucrat in the home of the great white father acquiesces to the request of the states, providing they do the job his way. Then he is willing to give back to the states some of the money which its citizens have paid to his department in taxes.

Why do Americans fall for this completely cockeyed idea? Why do they sigh in relief when the federal government pays the bill, when really they are footing it themselves? Why can't they face reality and pay enough local, county, and state taxes to provide these vital services which must be met?

It has been said that the American Bald Eagle is our national bird . . . the symbol of all that is good and great in the United States of America. This is also a delusion and a snare. These days our national bird, according to our actions, is the ostrich. He alone of all known creatures thinks he can by-pass danger by ignoring it. He sticks his head in the sands of time and lets his future and ours go by without a thought.

An ostrich is an awfully stupid bird.—G. Wilse Robinson, Jr., in "Bulletin" Jackson County (Mo.), November 26, 1955.

WOMEN'S AUXILIARY

The Pulaski County Medical Auxiliary had as their guest speaker, **Mrs. Mason G. Lawson, President of the Woman's Auxiliary to the American Medical Association.** The meeting was held at the Y.W.C.A. on Wednesday, December 21, 1955. Hostesses were Mrs. Alfred Kahn, Mrs. Frank Kumpuris, Mrs. Drew Agar, Mrs. Bill D. Stewart, and Mrs. A. J. Brizzolara. A trio from Central High composed of Marolyn Farris, Carolyn Farris and Sandra Sullivan sang Christmas Carols.

The wives of the Senior Medical Students at the University of Arkansas School of Medicine were the guests of the Board members of the Woman's Auxiliary to the Pulaski County Medical Society for the luncheon and meeting.

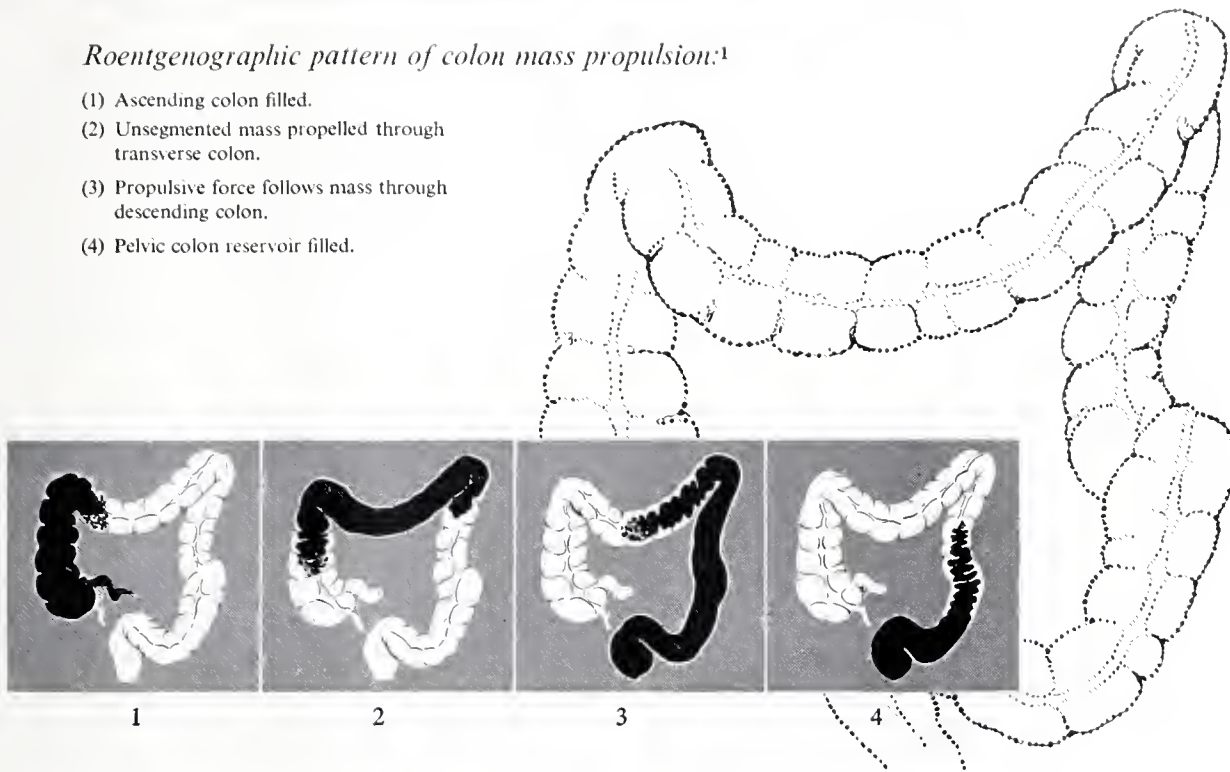
COLUMBIA COUNTY

All members of the Auxiliary to the Columbia County Medical Society acted as hostesses at the formal opening of the Magnolia City Hospital Annex Friday, December 30th from 2 'till 8 p.m.

SMOOTHAGE ACTION IN CONSTIPATION

*Roentgenographic pattern of colon mass propulsion:*¹

- (1) Ascending colon filled.
- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
- (4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

*Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.*²

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation. Metamucil (the mucilloid of *Plantago ovata*) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Correction of constipation logically, therefore, lies in the suitable adjustment of such factors as nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.²

The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and

it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and non-allergenic.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of one pound—also four ounces and eight ounces. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N.B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, *Gastroenterology* 13:275 (Oct.) 1949.

SEARLE

During the next two months the Auxiliary will sponsor a drive to raise funds to buy linens for the hospital.

The Woman's Auxiliary to the Pulaski County Medical Society met Wednesday, January 18, 1956, at the Y.W.C.A. The husbands of the members have been invited to attend this meeting. It was a meeting on Medical Legislation. Mr. Paul Schaefer, executive secretary of the Arkansas State Medical Society, discussed Medical Legislation with the physicians and their wives. Mrs. William G. Cooper is chairman of Medical Legislation for the Pulaski County Medical Auxiliary.

Hostesses for the luncheon were Mrs. Robert Henry, Mrs. John McCullough Smith, Mrs. John Laurens, Mrs. Thomas Burrow, and Mrs. Marion Craig.

Mrs. Verline Rainey, Secretary.

BOOK REVIEWS

Cardiac Diagnosis: Robert F. Rushmer, M.D., Associate Professor of Physiology and Biophysics, University of Washington Medical School. Pp. 444. Illustrated. 1955. W. B. Saunders Co., Philadelphia. \$11.50.

This book on the physiological approach to cardiac disease is timely, because of recent changes in the concepts of cardiology. It is divided into five parts: 1) The Function of the Normal Cardiovascular System; 2) The Regulation of the Cardiovascular System; 3) Congestive Heart Failure; 4) The Methods of Cardiac Diagnosis; and 5) The Diagnosis of Cardiac Disease. The anatomy of the heart and circulatory system is nicely pictured. The discussion on physiology presents many recent advances, and must be studied with care by the physician who is not primarily a cardiologist. An excellent review of cardiac reserve and left ventricular failure is given. Perhaps the most useful section of the book is that concerning the methods of cardiac diagnosis. This gives practical points on measurement of blood pressure, size of the heart, cardiac output, and evaluation of heart sounds and murmurs. A simple routine for analysis of electrocardiograms is given, and the study of electrocardiographic interpretations is presented by means of theoretical analysis as opposed to empirical diagnosis.

There is an excellent bibliography at the end of each chapter.

Application of the more practical points set forth in the book would undoubtedly improve the physician's interpretation of cardiac disease.—Ruth Ellis Lesh.

Polio Pioneers: Dorothy and Philip Sterling. Pp. 128. Illustrated. November, 1955, Doubleday and Company, New York. \$2.75.

One of a series of junior books of this publisher is presented. The scientific background of the production of the Salk Vaccine for Poliomyelitis is ably told in story form which is appropriate for junior and senior high school students.

The book is profusely illustrated—rather, it is over-illustrated—going afield as far as pictures of newspaper headlines. The text is not profuse and is ably written, clearly, accurately and entertainingly presented. The type is large and legible. This book will be a useful addition to school and children's libraries.

The Relief of Symptoms: Walter Modell, M.D., F.A.C.P., Associate Professor of Clinical Pharmacology, Cornell University Medical College. Pp. 450. 1955. \$8.00. W. B. Saunders Co., Philadelphia.

One is perplexed as to what is the mission of this well written, interesting book. It is not inclusive enough to be a text book of either medicine or pharmacology. It reviews 24 important symptoms which the author states comprises over 95% of the complaints which bring patients to physicians.

Of particular interest are the first five chapters. Here among other points, the author discusses the necessity for relieving the patient's symptoms; he wisely points out it is not enough to seek a diagnosis. There are excellent chapters on the placebo action of drugs and on the trial with the drug.

The actual chapters on the relief of symptoms are in some instances brief; there are, however, good bibliographic references throughout the book. There are good tables of drugs used for certain disorders listing their official name, proprietary name, mode of administration, and special uses.

A rare chapter seems to offer little in the way of concrete help as that on the loss of appetite but here again the amount of factual information in this field is limited.

In general, the author has written a very readable discussion of the therapy of symptoms. It is worth reading as an excellent selective summary of information on the titles which are included. To medical students, it should have a special appeal, as the therapy recommended seems most sound.—Alfred Kahn, Jr.

International Symposium on Cardiovascular Surgery: Henry Ford Hospital. Conrad R. Lam, M.D., Detroit. Surgeon-in Charge, Division of Thoracic Surgery, Henry Ford Hospital. Pp. 534. Illustrated. September, 1955. \$12.75. W. B. Saunders Co., Philadelphia.

This illuminating symposium brings one up to date on the studies being done in various parts of the world in experimental cardiovascular surgery, and its research. Contributors, other than the English speaking ones are from Sweden, Germany, Argentina, Denmark, and France. Almost half of the Medical Schools in the United States and Canada had participants in the discussion. The Symposium is the outgrowth of work by Richard J. Bing, Birmingham, Ala., in Cardiovascular physiology and correlates the advances being made in heart surgery being made everywhere.

There is a chapter on Diagnostic Techniques, followed by a number of chapters on specific entities. Pulmonic Stenosis; Mitral Stenosis and Mitral Insufficiency; Aortic Stenosis and Aortic Insufficiency; Cardiac Arrest; Septal Defects. There are many references and the index is more than adequate.

This is a book for the teacher and the student. It is the book for the surgeon-cardiologist who has visions of doing a better work tomorrow. It is beautifully edited and makes the general practitioner know that some day some of his unsolved problems will have an answer.

The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

March, 1956

No. 10

THE MEDICAL TEAM IN ARKANSAS*

LOUIS K. HUNDLEY, Chairman
Council of the Arkansas Medical Society
Pine Bluff, Arkansas

The conception of a medical team working together to save the life of a patient dates back to antiquity. In our modern civilization this team has become a highly complex organization almost unlimited as to number of personnel. It varies in size from the great Medical Centers of today to the smallest unit of medical service such as the Community clinic project recently inaugurated in Perry County, through the inspiration and aid of Winthrop Rockefeller. The medical team in its simplest aspect, to meet the requirements of modern medicine, consists of doctor, nurse, technician and office assistant. The aim of this type of unit is to bring the best possible medical care to the patient at a price he can afford to pay, and at the same time furnish to the Community necessary health services, designed to produce eventually a healthier and happier people. We believe that it is the type of medical care which will satisfy the American people that they have the best system of medical care in the world.

In the past three years at least two significant studies on medical care were completed here in Arkansas. The Nursing Function by Dr. Stewart and Mrs. Needham, and the Mental Health Survey by the Governor's Committee and the American Psychiatric Association. In each of these studies an evaluation of our present resources in medical personnel and institutions was made. It is perfectly obvious from these reports that our present situation leaves much to be desired. My colleagues have told you of the needs for additional trained nursing personnel, out of which has come this wonderful organization assembled here today. As practical nurses you are a comparatively new member of the medical team. Your birth and growth have come from the necessity to meet certain and specific needs especially in the area of hospital nursing. From the reports it seems clear that your duties and opportunities

have, like Topsy, just grown. Accompanying this growth there are and will be growing pains. With increasing numbers of licensed practical nurses becoming available, it behooves us to delineate and define the place you will occupy on this team, which we are striving to perfect.

In my opinion your first, and greatest field of endeavor should continue to be in Institutional Nursing. It is here that you can carry out the nursing function to best advantage, and eventually eliminate or greatly decrease the number of untrained personnel now, of necessity, being utilized to care for the hospitalized patient. However, I feel that as this load is lessened **by increased number of nurses available**, that there are other areas of Medical Service for which your training and ability will equip you, and which offer new and interesting fields of endeavor. Referring to the Mental Health survey I mentioned earlier, it is recognized that, with the increasing number of older persons in our population, the field of Geriatrics is becoming more and more important. Many physicians, recognizing this, are studying and even specializing in diseases of the aged. Recommendations to the Legislature for the long term Mental Health program include several large units for institutional care of the senile patient. As this program develops, I feel that this is a field in which the practical nurse should become most interested. Also proposed and contemplated in this report are institutions for the care of the Mental Defectives. A start has already been made by the last Legislature toward an institution for the care of the older defective children, and I feel sure that this colony will soon become a reality; but more interesting, an institution has been proposed in connection with the Medical Center for diagnosis and care of the infant to school age group. It is to be hoped that when this institution becomes a reality, as it surely must, you can have

*Address to Arkansas Practical Nurses Association, 1955.

a place in this sadly neglected field, both for post-graduate training and service.

Still another area toward which I feel you should direct your attention and carve out your niche on the medical team is—the care of the chronically ill. Having served on the staff of one of our great sanatoria for the care of the tuberculous patient for the past eight years, I have personal knowledge of the great difficulties under which these institutions struggle to provide adequate nursing care. I feel that our sanatoria provide an extremely high standard of medical treatment and yet, for the most part, nursing is carried out by aids; former patients trained by the institution itself to carry out minimal nursing functions, and yet these institutions provide almost the equivalent to a general hospital service; surgery, obstetrics, E.E.N.&T., gynecology, dentistry, pediatrics and geriatrics, along with some psychiatry are included in the overall medical service. At least one of these institutions is trying right now to set up a school for practical nursing, and I feel that your organization could render a most worth-

while service and at the same time widen its own field of endeavor by lending your blessing and assistance to this program.

In the short time allotted to me I cannot possibly cover all the fields which are beckoning to you to achieve your place on the medical team. With the progress of medical care there is plenty of work for all and there need be no overlapping. I can promise that the Arkansas Medical Society and The State Nursing Association, are happy to welcome you and will continue to aid and assist you in every way possible. Working together the members of our Medical team can provide improved service in the field of hospital nursing. Working together we can meet the challenge of the developing fields of psychiatric, geriatric, and tuberculous patient care. Working together we can keep step with Medical Progress. Progress comes not by some magic word, and not by Government edict, but from the thoughts, the toil, the tears, the triumphs of individuals who accept the challenge of raw material, and by the Grace of God-given talents produce results which satisfy the needs of men.



CASE REPORT

AMELANOTIC MELANOMA

M. J. KILBURY, SR., Pathologist
St. Vincent Infirmary

This patient is a colored female, age 50; she entered the hospital on November 1, 1955, under the service of Dr. N. Riegler, Jr.

She gave a history of having injured the little finger on the left hand about two years ago. This was followed by a severe perionychial infection which failed to heal. About 9 months ago, the finger was reinjured and this was followed by the loss of the nail.

She was taken to surgery with a diagnosis of pyogenic granuloma and the finger was amputated between the proximal and the middle phalanx.

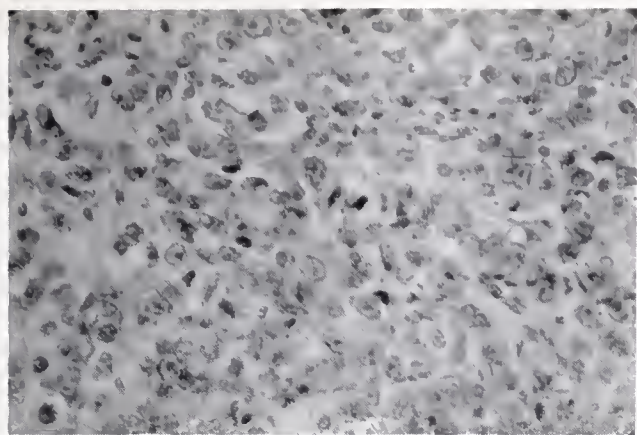
The specimen received in the laboratory consisted of the distal and middle phalanx of the little finger of the left hand. There was a considerable amount of granulation tissue over the dorsal surface which had replaced the nail and nail bed. Gross examination of the lesion revealed granula-

tion tissue overlying an organized layer of tissue which appeared to be neoplastic.

On microscopic examination, the lesion was found to be neoplastic. It was very cellular and there were extensive cell masses, largely spindle in shape, irregular in size, presenting outstanding nuclei and a great many mitotic figures. In some areas, there were rather definite circumscribed nests of cells of a large angular or round cell variety.

The picture at once was considered to be a newgrowth and the provisional diagnosis of sarcoma was made.

As the lesion was further studied other possibilities were considered: (1) Amelanotic melanoma was strongly considered as there were no pigmented cells present. (2) The possibility of glomus tumor was given considerable thought.



High Power

The glomus tumor is found in certain parts of the body where subcutaneous gloma are found. In certain parts of the body, there are peculiar types of arterio venous shunts, which transport the blood from the arterial to the venous system. These connect the arterioles with the venules by a so-called Suequet-Hoyer canals. These canals are used in certain conditions when the circulation of an increased amount of blood to the region is necessary. In and around these blood vessels are groups of cells which are called glomus cells. They resemble the intra-dural nevus cells. The comparatively rare glomus tumor is made up of these cells which proliferate quite extensively into round nests of cells or accumulate around the blood vessels. These tumors may be multiple; as many as 48 have been found in one individual. They appear as purplish-red spots varying from 5 mms. to 5 cms. in diameter. They are frequently diagnosed by a characteristic lancinating pain.

The glomus tumor is made up of a rather uniform cellular structure. There are practically no mitotic figures. There are usually some hemangiomatous manifestation, there being quite a number of blood vessels. This type of tumor is sometimes called the glomangioma. The glomus tumors have been found in the joints, in the stomach and in the region of the extremities and also the nail beds.

After considerable deliberation, it was decided that the tumor in the hand contained too many mitotic figures for this to be a glomus tumor. Mitotic figures could be found in nearly every field, and in some fields, one could see three or four definite mitotic figures. It was therefore decided, that the tumor must be more of a malignant nature. Since there is some question about the diagnosis, further opinions were obtained.

Slides were sent to Dr. L. C. Ackerman of St. Louis, and he returned a diagnosis of amelanotic

melanoma. He also recommended that the axillary lymphadenectomy should be done regardless of the presence of enlargement of the nodes.

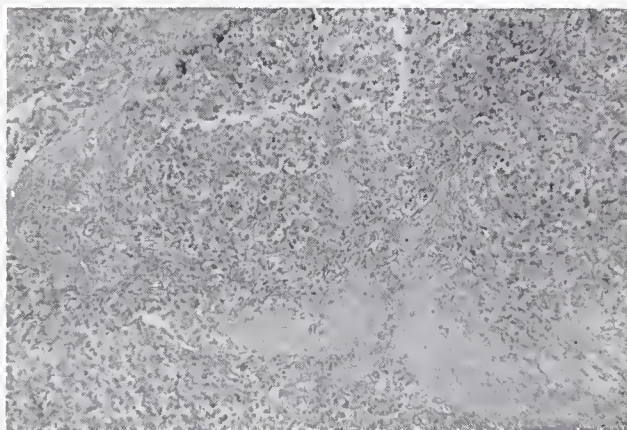
The reason for reporting this case is that tumors of the digits are comparatively rare. We are finding more of them at this time than formerly. This is probably due to the fact that there is more generalized study of these lesions. Perhaps many of the granulomatous lesions of the digits were thrown away without being examined in former years.

At the present time with thorough routine examination of tissues, such lesions as this are being more frequently found. This emphasizes the importance of thorough tissue examination.

The tumors most frequently found in the digits are the superficial epithelial types of tumors, such as warts, tumors of the tendon sheath and the glomus tumors which are rarely found. The melanotic tumors are quite frequently found in the toes and in the fingers. Melanotic tumors are not unusual around the toes and the metatarsal areas of the foot. One cannot predict the outcome in this case. It is possible that metastases have not taken place as yet, and the amputation may bring about a cure. But if the diagnosis of amelanotic melanoma is correct, it is quite probable that there will be metastases in the future. No further surgery is contemplated in this case, except for the resection of the axillary lymph glands.

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Lower Power

STATEMENT OF ARKANSAS MEDICAL SOCIETY

BEFORE FINANCE COMMITTEE, U. S. SENATE

FOUNT RICHARDSON, February 9, 1956

Mr. Chairman and Members of the Committee:

My name is Dr. Fount Richardson and I am engaged in active practice of medicine in Fayetteville, Arkansas.

There are many points that can be made, in discussion of H.R. 7225. There are two points against the bill which seem to me to be extremely important. I will speak only on these two.

The bill offers some relief of the disabled, and of his family. Fortunately, this problem is being taken care of already in Arkansas by the many agencies of the Federal Government, the state government, city and county governments, and many private and philanthropic organizations.

In preparing for this report, several of these various government agencies were approached with the question "What does a man do in Arkansas if he is totally and permanently disabled?" In one instance, the person in charge of the office told us that there were so many ways of taking care of the indigent, and helpless, that it would be a hopeless task to try to list them all.

The Rehabilitation people will pay a maintenance fund of \$15.00 per week for any individual who is taking a course of rehabilitation. It pays, of course, for his rehabilitation. In addition, the same individual is eligible for aid to dependent children, up to a maximum of \$105.00 per month. This is a federal function, already operating.

If the disability is caused by an injury covered by workmen's compensation, the individual would draw a percentage of his weekly salary for an indefinite period. I am told that some cases have gone five or six years. This is a state commission.

In the case of a person disabled who cannot be taught a gainful occupation, the Department of Public Welfare will pay, in the case of a person who does not need nursing care, \$35.00 per month, and \$55.00 a month if he must stay in bed and have nursing care. The head of the Department of Public Welfare, in Fort Smith, told us that there are excellent nursing homes in Arkansas which will accept patients for this sum. These payments are made from federal funds. If it develops that \$35.00 or \$55.00 is not sufficient, this amount can be, and is, supplemented by money

from the General Relief, and from the County Judge's fund.

In the case of blind persons, there is a monthly grant of \$55.00. These people are also set up in small businesses such as the sandwich and magazine stands, seen in banks and court houses all over the state. There are also some independent, benevolent foundations for the blind. One is operated by the Lions Club of Arkansas. Relief for the indigent and disabled is the largest business in Arkansas, and amounts to \$39,000,000 per year in state and federal funds. To me, that's a lot of tax money, and some of it's mine.

There are innumerable other sources of assistance for people in need of help. There are veterans' pensions, and hospitals, the UMW Retirement and Disability Plan, the Railroad Retirement and Disability Plan, the programs of the various churches, which, are well financed; crippled children's hospitals, Civil Service Retirement and Insurance Plans, and the disability benefits offered by the larger industries in Arkansas. In many counties there are the City Welfare Offices, and the County Pauper Commissions which also assist, where the federal and state money is not sufficient. We were advised that the Salvation Army does a tremendous job, and, in the cases of particular diseases, we have the Polio Foundation, the Tuberculosis Association, the Cancer Society, Multiple Sclerosis Association, and all the rest. These are all voluntary.

There is a children's hospital in Little Rock, where any crippled child, up to 18 years, is treated without cost. Our finest surgeons visit it every day without any charge. It is supported partly by state funds, but largely, by public charity. Many churches have a budget item for this hospital. These are voluntary public philanthropies, and they do an enormous amount for these children. The many Shriner's hospitals for the crippled are magnificent monuments to the generosity and willingness of man to help man in a voluntary way. The job is already being done.

We found that the surplus food distribution is no small item. There is no means test to receive this food, and anyone who states that he needs it, can get it. In Sebastian County, this amounts to about \$10.00 per person, per month, at the pres-

ent time. Butter, milk, lard, cheese, beans, flour, and meal, are some of the items being distributed.

In Arkansas, which is reputed to be one of the poorer states, a person disabled is not faced with the specter of starvation or medical neglect. The Public Welfare people have money available for hospitalization and medical care for any of their clients. Why should the Social Security System, already in questionable financial condition, and whose tax is becoming a burden to the people, be saddled with the addition of hundreds of thousands of "disabled" people who are able to get assistance already. It would simply be another duplication of government assistance which already overlaps itself. For the disabled, the law is not necessary. The job is being done now, and quite satisfactorily.

I believe that these local, state, and private organizations are doing the job the proper way. They are doing it voluntarily, they are doing it well. There is no need for H.R. 7225 in this field.

The second point I wish to make against the bill is more an ethical one. It concerns the whole Social Security. Social Security started as a small relief for the aged. It has grown, step by step, to a huge, tax-gathering, money-spending organization. These steps lead, every one of them, **away from** a democratic form of government, to a compulsion form of government. Call it what you will—my point is that these steps are simply in the wrong direction.

The American people have to move in the direction you gentlemen indicate. We pray you to have us step in the right direction.

STATEMENT ON H.R. 7225 TO SENATE FINANCE COMMITTEE

R. B. ROBINS, Camden, Arkansas

Senator Byrd and Members of the Senate Finance Committee:

I am interested in H.R. 7225 as a citizen as well as a physician. My interests relate to its actuarial soundness and its fiscal feasibility. I am equally alarmed when I am told that many people will soon pay more to the social security tax collector than they do to the income tax collector. The social security tax will become the No. 1 tax problem for many millions of people.

The tax rate on social security is soon going to be boosted so high that it is going to be distasteful to people, particularly self-employed people who have to pay half again as much as do wage earners.

When social security began in 1935 it had a clearly defined purpose and that was to guarantee an income for retired men and women. If it was the opening gun for a long-range, continually expanding, luxury type of program, no one was so advised at that time.

The much mentioned OASI trust fund is reminiscent of the British Labor Party's welfare state program. At the party's 54th Convention, former Health Minister Aneurin Bevan ridiculed proposals to keep the trust fund on a sound, actuarial basis. Bevan summed up his sentiments by saying, "Gentlemen, there **ain't** no fund." He added

that it had been poured into power stations, factories, and mining operations. It also went for housing subsidies, farm supports, and "free" medical care.

Our own trust fund remains strictly a fiscal myth. It contains about \$21 billion in I. O. U.'s signed by the United States Treasury. It draws interest of over 2 per cent. All very interesting. The federal government is not a self-supporting operation. Its existence hinges on continuous taxation. Consequently, interest payments must come out of taxes on the same people who originally were taxed to build up the trust fund. The interest now—just the interest—is more than half a billion a year. This, of course, will increase annually as the years go by. Isn't it much like borrowing money from a neighbor and returning later to borrow more money with which to pay the interest on the initial loan? Won't he some day tire of this vicious financial arrangement?

Every time Congress meets there are always new attempts made to broaden and liberalize the Social Security Law, as you well know. This present bill, H.R. 7225, includes several far-reaching provisions, one of which would make totally and permanently disabled persons eligible to receive their social security retirement benefits at age 50 instead of age 65. During the course of these hearings, much will be said about disability de-

termination and malingering. I would like to believe that no one would take advantage of a cash disability benefits provision. But, gentlemen, it won't work that way. Human nature doesn't permit it to work that way.

H.R. 7225 will give hundreds of thousands of potential malingerers the kind of opportunity they've been seeking for years. This is the reason, in my opinion, it makes it absolutely impossible to set up a realistic budget or to have an accurate idea what such a program will cost.

I understand that government experts regard the current OASI program as financially sound if we're willing to assume that the country will remain prosperous, that employment will remain high, that payroll taxes will periodically be increased, and that only the anticipated number of people will retire. Those are rather substantial "ifs." To me, it makes about as much sense as saying that a horse will remain well if he doesn't get sick.

The nation has already entered an era that puts undue confidence in subsidies, price supports, and shaky financial arrangements. The hand-out provisions of H.R. 7225 fall in that last category. They too clearly remind me of earlier theories which advocate redistribution of income.

One final point, gentlemen, and I am through. Reports have been circulating that a compromise may be offered on the proposed amendments of cash benefits for the permanently and totally disabled in this bill. It may be suggested that age 60 be set as the eligibility requirement for the disability benefits instead of age 50 as stipulated in the bill. The danger of such a compromise is obvious. Once the principle of permanent disability benefits is established — regardless of whether it is 60 or 50—there will be inevitable pressure in the years ahead to reduce and eventually eliminate the age requirement. It is the principle, not the age, which is important.

Gentlemen, in conclusion let me say that it is not pleasant for me to quarrel with anything that sounds so good, and kind, and humane as social security. It is like someone has said, "parading around a feast with a stomach pump." But, to me, this bill will have a far-reaching effect on the nation's economic, social, and political future.

Let me thank you for the opportunity of expressing my views.

FIFTY YEAR CLUB of the Arkansas Medical Society

All Doctors who have been in practice 50 years or more are urged to write J. H. McCurry, Cash, Arkansas, Secretary of the Club.

RESOLUTION

God in His infinite wisdom has called to Himself our respected and beloved colleague, Alvin Weil Strauss, Sr. A life given to alleviating the suffering and curing the ills of his patients has ended. Dr. Strauss dedicated his life to his patients, to the profession of medicine, and to his family. To him, the profession of medicine was divinely inspired and the highest to which to aspire.

The words of the Psalmist come to mind . . . "What is man that Thou art mindful of him? And the son of man that Thou visitest him? For Thou hast made him a little lower than the angels, and hast crowned him with glory and honour." To Alvin Weil Strauss, Sr., the position of a physician was but little lower than the angels. He tried at all times to maintain this place for the physician in the hearts of his patients and in the standard of practice he maintained. The glory he received was to be found in the deep respect and devotion of his patients toward him, in the devotion of his family, and the respect of his colleagues. These, too, gave him honor in the Community, but the greatest honor is to be found in the hearts of his bereaved family who cherish and treasure the hours of devotion and guidance he gave to them.

We, the Pulaski County Medical Society, also treasure our thoughts and memories of Dr. Strauss. We have lost a man whose life has been and will continue to be a guide to us as we pursue the practice of medicine.

Be It Resolved that the Pulaski County Medical Society express to the bereaved family of Dr. Alvin Weil Strauss, Sr., our sense of loss and extend our sympathies and condolences to them in their hour of grief.

Be It Further Resolved that a copy of these resolutions be sent to the family of Dr. Strauss, and that a copy be placed in the minutes of our meeting; and,

Be It Further Resolved that a copy of these resolutions be published in the Journal of The Arkansas Medical Society.

Ellery C. Gay, President,
H. Ray Fulmer, Secretary.

Jerome S. Levy, Chairman,
Louis A. Cohen,
E. C. Reed, Jr.

Contributors to the American Medical Education Foundation During the Month of January, 1956:

M. D. Deneke, West Memphis.
T. M. Durham, Jr., Hot Springs.

ANNUAL COMMITTEE REPORTS

COMMITTEE ON PUBLIC HEALTH

BEN N. SALTZMAN, Chairman

The Committee on Public Health has no function outside of its members acting as chairmen or members of the various sub-committees that comprise the public health picture in Arkansas. Most committees have been active and their reports are incorporated in the reports of the various committees of the Arkansas Medical Society.

Committee activity has been fairly marked this year, particularly with the work of the Polio Advisory Committee, the Rural Health Committee, the Mental Health Committee and the Committee on Tuberculosis. The various sub-committees of Public Health are as follows: Sub-Committee on Rural Health, Sub-Committee on Industrial Health, Sub-Committee on Tuberculosis, Sub-Committee on Mental Health, Sub-Committee on Liaison with the State Board of Health, and Polio Advisory Sub-Committee.

SUB-COMMITTEE ON RURAL HEALTH

BEN N. SALTZMAN, Chairman

The Committee on Rural Health this year has been active in both the promotion of a rural health conference for Arkansas and the development of a new plan for reaching the rural population of Arkansas. This committee is composed of the following: Tasker N. Rodman, M. D., Leachville; W. H. Pruitt, M. D., Camden; Duane E. Brothers, M. D., Ozark; John T. Herron, M. D., Little Rock; Robert F. Hyatt, Jr., M. D., Monticello; and Ben N. Saltzman, M. D., Mountain Home, Chairman.

The advisory committee this year consists of the following: Charles R. Henry, M. D., Council on Rural Health, American Medical Association; L. H. McDaniel, M. D., President, Arkansas Medical Society; Aubrey D. Gates, Field Director, Rural Health Council, American Medical Association; C. A. Vines, Associate Director, Agricultural Extension Service, University of Arkansas; Miss Helen Robinson, Health Education Specialist, Extension Service, University of Arkansas; Mrs. Hazel C. Jordan, State Home Demonstration Agent, Extension Service, University of Arkansas; Waldo Frasier, Executive Secretary, Arkansas Farm Bureau Federation; John T. Herron, M. D., State Health Officer; Mrs. Mason G. Lawson, President, Woman's Auxiliary to American Medical Association; Mrs. John T. Gray, President, Woman's Auxiliary to the Arkansas Medical Society; Mrs. H. C. Nicholson, Chairman, Rural Health Committee, Auxiliary to the Arkansas Medical Society; William L. Cloud, D. D. S., Arkansas State Dental Association; Bryant B. Pake, D. D. S., Arkansas State Dental Association; Mrs. R. B. Maxwell, President, Arkansas Council of Home Demonstration Clubs; and Mrs. William Wilkie, Chairman, Farm Bureau, Woman's Committee.

The Committee and Advisory Committee met several times this year and devised the following program, which was presented as the 5th Arkansas Rural Health Conference at the Hotel Marion in Little Rock, Arkansas, June 28 and 29, 1955.

The registration was in charge of the Woman's Auxiliary of the Arkansas Medical Society. Mrs. H. C. Nicholson, Chairman of the Auxiliary Rural Health Committee, functioned as Chairman of the Registration Committee.

Group singing was led by Milton Scott of Russellville, accompanied by Mrs. Jessie Brown, Little Rock. The session was officially opened by Ben N. Saltzman, M. D., who presided. The invocation was given by the Reverend Lawrence Maus, Pocahontas; this was followed with the Address of Welcome, given by Dr. L. H. McDaniel, Tyrone, President of the Arkansas Medical Society. Dr. Charles Henry covered the work of the Committee on Rural Health with a presentation entitled "Five Years of Teamwork." Dr. W. H. Pruitt started the work of the session with a talk entitled "Let's Get With It," in which he urged the people assembled to go home and organize rural health groups and get to work. Russell E. Frost, National State Representative of the American Dairy Association of Chicago, presented a talk on the practical aspects of nutrition. This was followed by a panel discussion with Dr. James Wortham acting as moderator. The members of the panel included the following: William Cloud, D. D. S., Little Rock, Arkansas State Dental Society; Miss Ruth Powell, Little Rock, State Supervisor, School Lunch Service, Department of Education; Mrs. Barbara McDonald, Little Rock, Senior Nutrition Consultant, Arkansas State Board of Health; and Mrs. Mescal D. Johnston, Little Rock, Specialist in Consumer Education, Extension Service, University of Arkansas.

The meeting was divided into discussion groups and Dr. Ben N. Saltzman acted as discussion leader.

That evening, a dinner was held in the ballroom of the Hotel Marion and Dr. Claude D. Head, Jr., presented the subject of medicine in civil defense.

The following day the meeting was presided over by Waldo Frasier, Executive Secretary, Arkansas Farm Bureau, Little Rock. "The Family's Responsibility for Health" was the subject of a panel discussion. The following participated as members of the panel: Duane Brothers, M. D., Ozark, Rural Health Committee, Arkansas Medical Society; J. C. Jones, Pottsville; Mrs. Robert Thompson, Rison, Arkansas Council of Home Demonstration Clubs; William Oxner, Marianna, and Joanne Knowles, Monticello.

The audience joined into the discussion afterwards. The audience had an opportunity to express its accomplishments during the year during a period entitled "Let Us Do Something." Dr. W. F. Crockett, Lafayette, Indiana, Chairman of the Council on Rural Health of the American Medical Association, summarized the meeting.

A large number of exhibits were prepared and presented by the following organizations: State Health Department, Arkansas Dental Association, Blue Cross-Blue Shield, Arkansas State Nurses Association, Arkansas League for Nurses Association, American National Red Cross, and the University of Arkansas School of Medicine.

The co-sponsors of the Rural Health Conference were the Agricultural Extension Service, the Arkansas Council of Home Demonstration Clubs, Arkansas Farm Bureau Federation, Arkansas State Dental Association, Arkansas State Board of Health, and the Woman's Auxiliary to the Arkansas Medical Society.

The conference was fairly well attended with a registration of 360. 28 physicians were present. 70 counties were represented. The organizations represented were as follows: The Medical Societies, Dental Society, Extension Service, Farm Bureau Federation, Home Demonstration

Clubs, Medical Society Auxiliary, Dental Society Auxiliary, American Medical Association, Blue Cross - Blue Shield, Nurses Association, Public Health, State Department of Education, Tuberculosis Association, Press, Pharmacists, American Dairy Association, Medical Assistants Society, P. T. A., Red Cross, 4-H Clubs and 41 visitors.

In summary, the committee was of the opinion that although the conference was successful it was time to promote a change in program and for the year 1956 present Rural Health to the people of Arkansas in a different form.

The group decided to join the rural development project sponsored by the Farm Bureau in presenting various aspects of rural health to eight different communities selected as leaders in Arkansas rural development. The conference is to be omitted this year but will probably be renewed the following year. The committee on Rural Health feels that it has done as much as could be expected with the rural health program as set forth by the Council on Rural Health of the American Medical Association and hopes to continue to function in a manner which will reflect credit to the Medical Society and promote better rural health in Arkansas.

SUB-COMMITTEE ON MATERNAL AND CHILD WELFARE

FRANCES C. ROTHERT, *Chairman*

The Sub-Committee on Maternal and Child Welfare has devoted most of its attention to the continued development of effective participation of the medical profession in the planning and carrying out of health service for school children. The sub-committee assumed charge of the Physicians Conference on School Health in connection with the Petit Jean Workshop on Health Education, which was attended by 14 representatives of the State Medical Society, including the entire sub-committee. One committee member (Dr. Crawley) represented the Society at the monthly meetings of the Joint Committee on Health Education of the State Departments of Health and Education. The chairman also participated in these meetings. Dr. Crawley and the chairman appeared with other members of the Joint Committee in a demonstration of its work at the convention of the American Public Health Association, and participated in the American Medical Association's Fifth National Conference on Physicians and Schools.

The sub-committee cooperated with the Academy of Pediatrics in giving workshops on premature and newborn care in Little Rock and Fort Smith, and with the Committee on Maternal Mortality Study of the Arkansas Obstetrics and Gynecology Society. It met with a staff member of the American Medical Association Committee on Maternal and Child Care and planned to join a meeting that this committee is holding on March 11 in Hot Springs with eight neighboring states. It is planning a 1956 Conference of Physicians on School Health at Mather Lodge in Petit Jean State Park, June 16-17.

Recommendation: That the members of this Society demonstrate their interest in Maternal and Child Welfare and exert leadership by participating in local school health councils, by acting as advisors to local schools on request, and by cooperating in studies of maternal and newborn care. All who have been active in school health work are invited to, and should attend, the Petit Jean Conference at Mather Lodge on June 16 and 17.

SUB-COMMITTEE ON INDUSTRIAL HEALTH

H. E. MOBLEY, *Chairman*

The Sub-Committee on Industrial Health has not been too active on new projects this year.

We have checked with the Arbitration Commission in regard to its work and progress. This Commission is functioning well, and the Committee is pleased with their work.

The Committee has also made preliminary plans for another postgraduate course at the University of Arkansas School of Medicine for the year 1956-57.

SUB-COMMITTEE ON TUBERCULOSIS

JEROME S. LEVY, *Chairman*

The Sub-Committee on Tuberculosis was called to order by the chairman, Dr. Jerome S. Levy, at his offices in Little Rock at one-thirty p.m., January 15, 1956. Members present were Dr. Levy, Dr. Sanford C. Monroe, Dr. Harley C. Darnall, Dr. Duane E. Brothers, Dr. Fred J. Gray, Jr.

In discussing the problem on the recalcitrant patient in Arkansas, with particular reference to Act 161, 1955, the following information was obtained:

In general, since the act went into effect on July 1, 1955, cooperation by the two state sanatoriums has been good, but there has apparently been some lag in seeking out those patients who should be committed to the sanatoria on the act. At the McRae Sanatorium, six patients have been committed under Act 161, they have all been cooperative, and there has been no need for restraint although facilities are available for confining the patients if necessary. At the sanatorium at Booneville, seven patients have been committed under the act, one left against medical advice before necessary lock-up equipment had been installed, one has been sent to the State Hospital for examination, and five are being cared for without restraint and with good cooperation. Programs for indoctrination at both institutions have apparently been improved.

The following recommendations are made:

1. That a letter be sent to all practitioners of medicine, members of the State Society, under its auspices, acquainting them with the simple mechanics of having a patient committed under Act 161, and emphasizing their obligation to their community of removing active cases from public places.
2. That the Arkansas Tuberculosis Association be encouraged to continue a program of publicity to keep the public reminded of the existence of Act 161 and how it affects and protects the citizens of Arkansas.
3. That the methods of tuberculosis control and treatment be constantly made available to the physicians of the state through, a. inclusion of a nationally known speaker on tuberculosis in the program of the State Society, b. frequent use of speakers on tuberculosis at the district meetings and, c. the inclusion of a nationally known speaker on tuberculosis at the meeting of the Arkansas Association of General Practitioners, d. the use of an exhibit at the State Medical Society Meeting.

It is further recommended that, in view of the ever-present waiting list for colored patients at the McRae Sanatorium, that a Sub-Committee of this Committee on Tuberculosis, consisting of doctors from the State Society be made available to that institution to survey needs and make recommendations for increased capacity, if that in-

stitution desires and needs this in their arguments for expanded facilities before the state legislative body.

It is recommended that a Sub-Committee of this Committee on tuberculosis be appointed from the State Medical Society to investigate the facilities at the State Sanatorium at Booneville and its branch at Wildcat Mountain with the purpose of combining these two facilities if and when the patient load will allow. It is understood that at the present time the recall of known active patients on leave of absence and patients being sent to the Sanatorium under Act 161 has created a necessity for the additional beds at the Wildcat Mountain branch.

It is felt that the problem of tuberculosis in the State of Arkansas is still great and that all agencies concerned should continue their efforts in all fields of control.

SUB-COMMITTEE ON MENTAL HEALTH

E. H. CRAWFIS, Chairman

There has been no activity in our committee in recent months; therefore, I do not have anything to report at this time.

SUB-COMMITTEE ON LIAISON WITH THE STATE BOARD OF HEALTH

JOHN T. HERRON, Chairman

No matters have been brought before the Committee on Liaison with the State Board of Health during the past year, and because of this reason this committee has no report on activities to make.

POLIO ADVISORY SUB-COMMITTEE

EUGENE H. CRAWLEY, Chairman

The Polio Advisory Sub-Committee respectfully submits its report for the year of 1955 concerning its activities and recommendations to the president and council of the Arkansas Medical Society. This report includes the activities of the committee and its chairman who represented the committee and society on other committees of other groups concerned with polio problems.

The Sub-Committee has been concerned with two categories of activity. Due to the urgency of the problems that confronted us and the extensive pressure brought to bear on the committee by the public press, and by the great need for aid and advice to the members of the society. The first category of activity was the planning of the Polio Vaccine Programs that were required to provide and allocate the vaccine for the schools, physicians and public vaccine programs. The second category was liaison with the National Foundation for Infantile Paralysis (N.F.I.P.) and the Crippled Children's Division of the State Welfare Department (C.C.D.) on mutual problems of the polio patient care. This has consisted of meetings and conferences with the various representatives to discuss and draft policies to our mutual interests.

I. The polio vaccine programs:

The first vaccine program was that developed in cooperation with the N.F.I.P. and the State Health and Education Departments for the administration of the polio vaccine, provided by the N.F.I.P., to the first, second and third grade school children. The first injection was given in May

according to the plan with good response by all agencies, physicians and parents. The second injection was given in many schools before the vaccine supply was exhausted and school was out for the summer. The second injection was completed in the other schools in October. About 80,000 children in the state received one or both of the injections and were instructed to obtain their third injection seven months after the second one from their family physicians or public health programs. This program was outlined and sent to all physicians in the state last May. Due to its early drafting this program served as one of the models for the National N.F.I.P. plan presented as a guide to other states.

A second plan for the voluntary distribution of the vaccine by private physician was developed in an effort to avoid the inevitable government controls that were in the process of being drafted by Congress at that time. Copies of this plan were mailed to all members of the society. In brief, this plan was a summation of the problem and recommendation to private physicians on the manner in which they should administer the vaccine in their offices. This plan was a modification of recommendations made by the American Academy of Pediatrics and the A.M.A.

This plan was soon superseded by regulations set up by the Department of Health, Education and Welfare. The vaccine was distributed upon their recommendations to the respective states that conformed to the regulations as set up by the National Advisory Committee. Therefore, a second voluntary plan for private distribution was drafted to conform to the national regulations, in order that physicians in Arkansas could receive their share of the vaccine.

A state committee for distribution of the polio vaccine was formed by the state health officer, Dr. John Herron who was director of the program and chairman of the Committee, and the Chairman of the Medical Society Polio Advisory Committee as a member. This committee adopted a plan of distribution of commercial polio vaccine for druggist, wholesale druggist and physicians. The plan was approved by the Arkansas Medical Society Council and was distributed to the membership by letter and the complete plan was published in the Arkansas Medical Journal, Vol. LII, No. 7, December, 1955.

In July, 1955, Congress enacted the Poliomyelitis Vaccination Assistance Act, providing funds for purchase of polio vaccine to be given to specified age groups and pregnant women and that no means test could be used for eligibility. The Advisory Committee was asked to work with the State Health Officer and his committee and provide a plan that would be mutually acceptable and meet the necessary requirements of the Congressional Act. The plan was made and submitted for the council's approval after modifications at two sessions of the council a modified plan was adopted by the council and was approved by the Public Health Department. This plan is now being put into effect over the state where approved by the local societies. Further comment on this and further plans will be summarized at the end of this report in our recommendations.

II. The second category of this Sub-Committee's activity was liaison with other organizations and especially with the N.F.I.P. In this capacity this committee has had numerous conferences and meetings with the various representatives of the state office and national directors of the N.F.I.P. to pass on various problems that involved physicians and patients.

A growing problem and activity that has had mutual participation is that of an education program conducted

by the N.F.I.P. to clarify and promote the vaccination of all eligible people in the state by whatever sources that may be available in the community. This committee co-operated with the N.F.I.P. in organizing their various programs to disseminate information and passing on their medical problems where they existed at the state level.

The chief problem as presented by the N.F.I.P. has been that of the existing medical fee plan that now is in effect and was adopted by the Arkansas Medical Society. The fee schedule was patterned after that use by Pulaski County and is not applicable on a state-wide basis in many instances.

The N.F.I.P. wishes to be relieved of the fee schedule and allow the physician and patient to negotiate their own arrangements in regards to the physician's fees, to be collected from the family where they are able to pay. The N.F.I.P. proposes to continue to participate in all other phases of patient care as they previously have done. They call attention to the fact that in many parts of the state physicians are not rendering fees to the N.F.I.P. and that the N.F.I.P. pays physicians' fees in less than one-fourth of the chapters on a national average. They contend that the present fee schedule arose as a result of an epidemic and was not a normal situation and now that polio has ceased to be an epidemic emergency, they wish to be relieved of the obligation. At present there is a great need for reevaluation of the fee schedule in line with present medical practices and present fees if the society wishes them to continue in effect. The committee has been polled in regards to their feelings on the matter. The majority are in favor of eliminating the fee schedule entirely and allowing the physician to make his own arrangements with the family and patient. Any assistance given by the N.F.I.P. would be decided by the patient and the local chapter of the N.F.I.P. and all physician fees would be rendered directly to the patient. As the condition now exists, the physician is obligated to accept his fees on the basis of the schedule regardless of the extent of the services rendered, or the ability of the patient to pay now or at a later date. Only one member of the committee favored the present fee schedule as it now stands. The committee felt, however, that the above recommendation should be subject to alterations in emergency conditions such as epidemics and other adverse conditions.

Summary and recommendations:

(a) 1. This committee goes on record opposing all forms of government control of distribution and administration of any vaccine or substance that circumvent or interfere with the normal supply and demand or supersede the normal ethical physician-patient relations. We feel that the polio vaccine as well as other therapeutic agent should remain in the hands of the individual physician and that he decide on its indications and use by ethical and scientific criteria.

2. We urge vigorous opposition by the society and individual physicians to any further encroachments on physician-patient relations, as well as public rejection of any further extension of the present government vaccine program acts as have been passed by Congress.

(b) We feel that the public should be informed on the efficacy of the vaccine and be urged to take it, as a public health measure and in case of indigency some means should be found to provide for them. Even with limited vaccination the fact has already been established that polio can be rendered an even more minor disease than it is at present. Every effort should be made to promote public education on the facts of the problem.

(c) In every endeavor or plan this committee has made an effort to keep all decisions and planning at a local level, allowing each community or group the responsibility of solving its own individual problems as it considers best.

(d) We recommend further and closer cooperation with the N.F.I.P. polio is a medical problem and its management requires close medical supervision that cannot always be delegated to anyone, but a physician. Every effort should be made to extend advice and direction to the N.F.I.P. in the management of their patient care program both locally and at the state level.

(e) The majority opposes the present medical fee schedule now in effect, and recommend that it be abolished and allow each physician to make his own arrangements for his services. We feel the present fee system imperils patient relations and sets a bad precedent with the public in that they have no obligations to pay for any medical service because it will be covered by special organizations or groups.

FIRST COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

R. C. SHANLEVER, Chairman

This Committee had only one complaint during 1955, which was from a lady in Memphis, about what she thought was an overcharge made for treatment of her mother in a Blytheville hospital.

After communicating with other members of my Committee by telephone, also talking with the doctor who had attended her mother, and some correspondence with the party who made the complaint, the conditions were settled satisfactorily between the client and doctor.

SECOND COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

O. J. T. JOHNSTON, Chairman

There has been no activity of the Professional Relations Committee in the Second Councilor District.

THIRD COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

MILTON C. JOHN, JR., Chairman

During the past year no complaints have been brought to the attention of the Third Councilor District Professional Relations Committee. Each member of the Committee representing the respective county societies have been contacted and they report that no grievance was filed with their society.

FOURTH COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

H. T. SMITH, Chairman

There have been no complaints brought before the Fourth Councilor District Professional Relations Committee during the past year.

SIXTH COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

R. R. KIRKPATRICK, Chairman

No complaints have been received by the Sixth Councilor District Professional Relations Committee during the last year and, therefore, the committee has been inactive.

I am confident that some dissatisfied patients should have been interviewed but, not knowing who they were or what their complaints were, it has been impossible for us to do anything.

SEVENTH COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

JACK W. KENNEDY, Chairman

In March, 1955, the case came up at Hot Springs involving a doctor and an elderly lady who had broken her hip. The contention was regarding the price that was charged for setting the lady's hip and the care that was given her during the time of hospitalization; and settling this without undue disturbance was accomplished by negotiating between the patient and the doctor. It was settled possibly two weeks following the initial complaint in that the lady agreed to pay a certain part of the bill which the doctor said he would charge after the situation was brought up. This was done in due form.

The next case in our district involved a woman in Clark County. The lady claimed that certain injuries were received during a delivery. This was proved false after several letters were written to the doctor who had seen the lady following the delivery and all the evidence of any injury was ruled out and the judgment of the committee was that this was a false accusation. The lady involved was so informed and it was explained to her some of the procedures that were carried out and that it had not harmed her in the least. This was all taken care of through a Hot Springs group. We have heard nothing further from the lady; apparently she is satisfied. This did not go further than the local professional relations committee.

EIGHTH COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

HENRY HOLLENBERG, Chairman

During the past year this Committee has continued to function somewhat as a County Medical Society Committee and without much correlation with the State Committee or other District Committees.

We have continued to receive and dispose of such unsolicited complaints as have come through the offices of the Pulaski County Medical Society and the State Society. During the past year three such complaints have been satisfactorily handled.

The most interesting and important development in Pulaski County has been action by the Pulaski County Medical Society to form a Grievance Committee of this County Society. This matter has been studied by a very capable and active public Relations Committee of our County Society and it has been their recommendation that a considerably wider approach to this problem be carried out. The members of our District Committee approve of the formation of this County Committee and are glad to turn over the bulk of duties to them. On the basis of our

experience it would be our warning to them and to any other counties which may take up a similar arrangement that their deliberations should be carefully correlated with our legal representatives. We are quite sure that there are many pitfalls regarding the sensibilities of our own members and of their patients which need to be carefully guarded.

TENTH COUNCILOR DISTRICT PROFESSIONAL RELATIONS COMMITTEE

ART B. MARTIN, Chairman

The Tenth District Professional Relations Committee wishes to report that there has been no activity of our committee during the past year.

COMMITTEE ON MEDICAL EDUCATION

H. W. THOMAS, Chairman

The Medical Education Committee, composed of Dr. James Kolb, Dr. Jack Kennedy, Dr. Alfred Kahn, Dr. C. C. Long, Dr. Roger Dickinson and Dr. H. W. Thomas, met only once during the past year. It will be recalled that this committee, during the preceding two years, met numerous times. The various members traveled several thousand miles and after much study, certain specific recommendations were made relative to the operation of the University of Arkansas Medical Center. These recommendations were made with the constant advice and counsel of the Administration of the University of Arkansas School of Medicine, and were approved by the House of Delegates of the Arkansas Medical Society. It may further be recalled that at the 1955 annual meeting of the Arkansas Medical Society, the resignation of Dr. H. C. Nicholson as Dean of the School of Medicine and some of the reasons therefor were discussed at some length.

With the changes in the Administration of the Medical Center, it was apparent that recommendations previously made by this Committee to the Medical Center Administration would not be effected; at least not in the immediate future.

In view of this situation, it was felt that this Committee could best serve the interests of Medical Education in Arkansas by taking no definite action or making no specific recommendations at this time.

Accordingly, this Committee met only once, on November 9, 1955, at the University of Arkansas School of Medicine. Dr. F. Douglas Lawrason, the new Provost for Medical Affairs, met with the Committee. The meeting was devoted to a review of the past activities of this Committee and its relationship with the Administration of the Medical Center up to this time.

Dr. Lawrason was assured that this Committee and the Arkansas Medical Society stood ready to help the Medical Center in any way possible. Attention was called to the fact that it was largely through the efforts of the Arkansas Medical Society that the present Medical Center is now nearing completion. It was further pointed out that only with the continued active support of the Arkansas Medical Society can the Medical Center hope to function at its maximum potential.

Dr. Lawrason stated that he had received the very best cooperation from all administrative departments of the Medical Center and the University of Arkansas.

The meeting closed with the statement that for the time being, the Committee had no further recommendations to make, but stood ready to help the Administration of the Medical Center in any way possible.

SUB-COMMITTEE ON POSTGRADUATE EDUCATION

WILLIS E. BROWN, Chairman

The Sub-Committee on Postgraduate Medical Education for the Arkansas State Medical Society has had some curtailments of its functions during the past year due to the complications associated with moving into the new facilities of the Medical Center. We continue to appreciate the support of the profession as a whole and the several organizations sponsoring the Postgraduate work.

At the time of this report most of the Postgraduate activities for the fiscal year (1955-56) have not been completed.

The following is a program of these activities for the fiscal year:

November 18-19, 1955—

DEPARTMENT OF ANESTHESIOLOGY — Cecil W. Shafer, Associate Professor of Surgery (Anesthesia).

February 29, 1956—

DEPARTMENT OF PSYCHIATRY — Seminar in Clinical Psychology—Wm. G. Reese, Professor and Head of Department; Sidney J. Fields, Ph.D., Program Chairman.

March 1-2, 1956—

PSYCHIATRY—Fort Roots, North Little Rock.

March 12-13, 1956—

AMERICAN COLLEGE OF SURGEONS, Little Rock.

March 28-29, 1956—

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY —Willis E. Brown, Professor and Head of Department.

April 23-25, 1956—

ARKANSAS MEDICAL SOCIETY, Little Rock.

May 14-15-16, 1956—

DEPARTMENT OF SURGERY—James H. Growdon, Professor and Head of Department.

It is anticipated that once the move to the new Medical Center has been accomplished that Postgraduate activities will be accelerated and that the report of this Committee in future years will show greater activity.

COMMITTEE ON HOSPITALS

GUY SHRIGLEY, Chairman

The only business, other than routine matters, which required the attention of this committee has been consideration of methods by which we might accomplish the directives set forth in the resolution of our House of Delegates passed in 1954 opposing any insurance plan listing anesthesiology, pathology, and radiology as a hospital service rather than as a medical service.

The committee tentatively planned a called meeting last fall to discuss this situation with a view towards taking some positive action to submit in a formal report at the

1956 annual meeting. However, we discovered that the Iowa State Medical Society has a similar problem in litigation, and it was deemed advisable and timely to pursue this case to conclusion in order that we might use the ruling of the courts as a precedent for our course of action. This committee is extremely happy to report that the Supreme Court of Iowa ruled in favor of the Iowa State Medical Society on this action. As we expected, the case was appealed to the higher court, and a decision has not yet been handed down. This committee therefore feels that a continued study of the situation in Iowa will soon provide us with a tangible solution which can be adapted to the needs of our state.

This report is informational in nature, and requires no formal action.

COMMITTEE ON LIAISON WITH BLUE CROSS - BLUE SHIELD

SAM G. JAMESON, Chairman

This Committee met on May 31, 1955, at the Arlington Hotel, Hot Springs, Arkansas. Liaison Committee members present: Drs. Gerald Teasley, Howard Stern, and B. D. Stewart. Absent: Drs. A. S. Koenig and Sam G. Jameson, both because of hospital confinement. Blue Cross-Blue Shield representatives present: Messrs. Jack Redheffer, Al Ercolano, and Rick Campbell.

The resolution by the American College of Surgeons requesting Blue Cross-Blue Shield plans to pay an assistant's fee in surgical cases was discussed. It was decided to refer this problem to all members of the Liaison Committee for extensive discussion with colleagues before making any recommendation to the House of Delegates of the Arkansas Medical Society. The Physicians Relations Program between the Arkansas Medical Society and Blue Cross-Blue Shield was discussed, with a report being made by Mr. Ercolano that plans had been completed for contact by Blue Cross-Blue Shield with all components of the Arkansas Medical Society.

This Committee met again on September 28, 1955, at Hotel Grimm, Texarkana, Arkansas. Liaison Committee members present: Drs. R. C. Dickinson, Gerald Teasley, and Sam G. Jameson. Absent: Drs. Ellery Gay and A. S. Koenig, both because of engagements out of the state. Blue Cross-Blue Shield representatives present: Mr. A. G. Bedell, Mr. Al Ercolano, and Mr. Gene Lopez. Mr. Paul Schaefer, Executive Secretary of the Arkansas Medical Society, was a guest.

The Committee discussed the resolution by the American College of Surgeons regarding payment of an assistant's fee in surgical cases, and a motion was unanimously passed that the Liaison Committee with Blue Cross-Blue Shield of the Arkansas Medical Society is opposed to any plan calling for such a payment, and further recommended that this report be presented to the House of Delegates of the Arkansas Medical Society at its next annual meeting in Little Rock. The principal reasons for rejection of this resolution by the American College of Surgeons are as follows:

1. If surgical assistant fees are to be paid by Blue Shield, the premiums are going to have to be increased or else the present surgical schedule will have to be decreased.
2. To include payment of surgical assistant fees by Blue Shield will increase the length of the claim forms,

as well as the administrative work in the Blue Cross-Blue Shield office. We all know that one of the advantages of Blue Cross-Blue Shield is the brevity and simplicity of the claim forms, as well as the speed with which claims are processed and paid. By increasing the length of or the number of forms, Blue Cross-Blue Shield will either have to hire additional administrative employees or else take longer to process each claim. Again, it is well known that increasing the administrative work also increases the operating costs, which in turn will have to be paid by either decreasing the services rendered or increasing the premium costs.

A report was made on the Physicians Relations Program, and it was the feeling of this Committee that this program is being handled very capably and is doing much to further the good relations which already now exist between the Arkansas State Medical Society and the Arkansas Blue Cross-Blue Shield plan. It was reported that all components of the Arkansas Medical Society have been contacted regarding a date on which they would like to have a representative of Blue Cross-Blue Shield meet with them, and many components of the state organization have already had informal discussions with a representative of Blue Cross-Blue Shield.

The Committee also discussed the undesirable effects which certain insurance companies were having on the voluntary health insurance program and the medical profession itself. It can only be true that the chain of voluntary health insurance companies fighting compulsory health insurance (or any other similar Federal program) can be no stronger than the weakest company which is operating in this chain. It was suggested that this program be studied and discussed at length at the next Committee meeting, with the expectancy of deciding upon constructive suggestions and criticisms which would in effect markedly strengthen our chain of voluntary health insurance companies operating in Arkansas.

SUB-COMMITTEE ON LIAISON WITH THE NURSING PROFESSION

HOYT CHOATE, Chairman

The professional nurses are accepting the increased supervisory and managerial duties forced upon them by lack of personnel. This shortage is due to an increased demand for their services and not to a decrease in trained nurses. This condition has been increasing for years and will continue to increase with expanding Veteran, Public Health and Industrial demands for nurses.

The nurses' organization has been instrumental in promoting the first work-shop for teacher training of nurses aides held at Fort Roots in December, 1955.

The legislative committee for a new nurse practice act has included a member of the Arkansas Medical Society on its advisory committee for the first time.

The professional nurse leaders are interested in preparing nurses for this new supervisory leadership by training programs in the schools. The Public Health program has donated almost 15,000 dollars to a nurse research project on hospital records for 1956. This is a follow-up of the nurse function study project of 1955 which expended over 22,000 dollars of National and State nurses funds.

More men are now interested in professional nursing careers than ever before.

The nursing profession seems acutely aware of its increased responsibility and is anxious for a better understanding with the Medical profession and hospital management. Now is the time it seems for our society to make an effort toward this better Physician-Nurse understanding.

SUB-COMMITTEE ON LIAISON WITH THE AUXILIARY

J. HARRY HAYES, Chairman

The Sub-Committee on Liaison with the Auxiliary wishes to report its activities as follows:

The first problem coming before this committee was to decide whether the Woman's Auxiliary to the Arkansas Medical Society should take out a membership with the American Public Health Association. The committee advised, and the Auxiliary decided, that membership in the American Public Health Association should be deferred until, and when, the Arkansas Medical Society made its decision whether or not they would have membership. At its meeting on September the 25th the Council of the Arkansas Medical Society voted to join American Public Health Association and the President of the Auxiliary, Mrs. John T. Gray, was so notified so that she might take action.

The second problem that the committee encountered was whether the Medical Society would aid financially in sponsoring a contest in the state, among the different papers and periodicals, for the article published which was most beneficial to the Medical Profession. The purpose of such an endeavor was to get favorable publicity, and to get it on a state-wide basis. The membership of the Advisory Board was canvassed and information sent to the Executive Secretary of the State Medical Society. The committee was, in reality, in favor of such procedure and to please submit it to the Council so the Auxiliary would know what they could depend on.

The third activity that the Advisory Board was called upon for was a survey to determine the number of mentally retarded children in the State of Arkansas. A number of letters were written and many telephone conversations were made with members of the Arkansas Children's Colony Board. They were highly desirous of having such a survey made in the State of Arkansas, but at the present time they are not in a position to advise the Woman's Auxiliary of just how such a survey should be conducted. There was a recent meeting in Arkansas at which Mr. Richard H. Hungerford, Superintendent of LoConia State School in New Hampshire, was present, Dr. Rosenzweig of Hot Springs, Arkansas, who is a member of the Board, and Mr. Florentz and others, with no definite plan stated as to how such a survey should be conducted. The Chairman of the Advisory Board to the Auxiliary stated that the Auxiliary was very anxious to help, and would lend its efforts when a decision was made as to how the work should be and could be conducted.

On Friday, January the 27th, a meeting of the Woman's Auxiliary was held in the Woman's City Club in the city of Little Rock, Arkansas. Mrs. John T. Gray, President of the Woman's Auxiliary, presided and the Chairman of the Sub-Committee to the Woman's Auxiliary from the State Medical Society, Dr. J. Harry Hayes, was present and addressed this group of ladies.

COMMITTEE ON VETERANS
ADMINISTRATION AFFAIRS
ELVIN SHUFFIELD, Chairman

There has been very little action on the part of this Committee during the past year. Several individuals have made talks to civic clubs pertaining to the operation of the Veterans Administration and the exorbitant cost of hospitalization, and the unnecessary occasion for hospitalization. But as a whole the doctors do not seem to be too interested in this problem, or else the doctors have some fear of offending the public concerning this problem. Also, the A.M.A. headquarters are apparently redirecting their thoughts, or else they have temporarily stopped operating, because we have not had any correspondence pertaining to the Veterans Administration Affairs in several months.

These abuses of our tax money should be kept before the public's eye, and our Congressmen should be thoroughly impressed that the American Legion does not represent but a very small fraction of the veterans of World War I and World War II, and that their thoughts do not represent the thinking of most of our veterans in the United States.

REPORT OF DELEGATES TO
AMERICAN MEDICAL ASSOCIATION
JAMES KOLB, Delegate

It was my happy privilege to again serve as a delegate to the American Medical Association in Boston, Mass., November 29th to December 2nd, 1955, as a co-delegate with R. B. Robins. My prediction in the August issue has come to pass. Bob has been selected as one of the three members of the House of Delegates, who are general practitioners, on a special five-man committee appointed by the Speaker of the House of Delegates, to conduct a study of the relative value of diagnostic, medical and surgical services and to report its findings and recommendations to the House of Delegates in the same manner as is now followed by other committees and councils of the Association (see page 1549, J.A.M.A., Vol. 159, No. 16, Dec. 17, 1955, for more detail).

Your delegates introduced Resolution No. 1, Commending the Women's Auxiliary to the American Medical Association for their past activities and requesting them to continue their efforts in raising funds for Medical education by urging each of its constituent auxiliaries to participate actively in financial support of the American Medical Education Foundation. Resolution No. 33, Recognition of General Practitioners in Hospitals, recommending that the American Medical Association through its council on Medical Education and Hospitals encourage hospital staff rules which permit the general practitioner staff member privileges in the specialty departments in keeping with his merit and demonstrated ability; and that the American Medical Association instruct its representatives on the Joint Commission on Accreditation of Hospitals to seek the adoption of the above recommendation by the body.

Both of these recommendations were passed by the House of Delegates without a dissenting vote.

Your delegates appeared before various reference committees and aided in the passage of several important resolutions.

I would like to suggest and request that each member read the Abstract of Reports that started in the organizational section of the A.M.A., dated December 17, 1955.

ANNUAL REPORT
OF THE STATE BOARD OF HEALTH
TO THE STATE MEDICAL SOCIETY
For the Calendar Year 1955
JOHN T. HERRON, State Health Officer

Vital Statistics

The ten principal causes of death in 1954 and their rates were:

Cause of Death	Number of Deaths	Rate per 100,000 Population
Heart (all types)	4,403	230.6
Neoplasm (cancer)	2,118	110.9
Vascular lesions affecting the central nervous system	2,068	108.9
Accidents	1,097	57.4
Pneumonia (all forms)	478	25.0
Nephritis (all forms)	396	20.7
Birth injury, asphyxia, and infection of newborn	312	16.3
Tuberculosis (all forms)	304	15.9
Unqualified immaturity (prematurity)	215	11.3
(a) Unspecified diseases of intestines and peritoneum....	208	10.9
(b) Diseases of liver, gall- bladder, and pancreas	208	10.9

43,747 births were recorded in Arkansas in 1954. This represents a rate of 22.9 per 1,000 population.

15,448 deaths were recorded in 1954, representing a death rate of 8.1 per 1,000 population.

1,158 infant deaths were recorded in 1954, representing a rate of 26.5 per 1,000 population.

39 maternal deaths were recorded in 1954, representing a rate of .9 per 1,000 live births.

Due to the lack of adequate funds to employ additional personnel we have not been able, for several years, to stay current with all of our work. However, due to better planning and more modern equipment we are endeavoring to prevent the accumulation of any additional backlog in the work.

Communicable Disease Division

It is not possible in a brief report to review all of the progress and problems of the Communicable Disease Division. However, since so much time and effort have been devoted to the prophylaxis of poliomyelitis by the use of Salk Vaccine, it is of interest to note preliminary results of its use.

The following data reveal the marked lowering of the paralytic polio rate, as compared with non-vaccinated 5-9-year-old children:

1955 Poliomyelitis Rates, by Age and Vaccination Status:

	Population	Paralytic	Cases Nonparalytic	Total	Paralytic	Rates per 100,000 Nonparalytic	Total
5-9 age group	202,063	23	29	52	11.4	14.3	20.5
5-9 vaccinated	87,832	4	12	16	4.6	13.8	18.4
5-9 non-vaccinated	114,231	19	17	36	16.6	14.9	31.6

The above figures are those of the NFIP program only.

The problem of diseases of animals transmissible to man is one of increasing importance, and during the year a Public Health Veterinarian was assigned to make epidemiological studies of these diseases. In addition to the ever-important rabies, investigations have been made in scattered areas of the State of blastomycosis, leptospirosis (Weil's Disease), cysticercosis, suspected anthrax and suspected glanders. An animal disease morbidity reporting system has been begun. The veterinarians are cooperating by reporting the diseases seen in their practice.

Maternal and Child Health Division

Consultants supervised hearing-screening programs in schools in 35 counties for 43,000 children, and vision-screening in 50 counties for 63,000 children. Of these, approximately 6,000 were referred for medical attention. Two Workshops on School Health were conducted jointly with the Department of Education for 110 school and health personnel, with 51 representatives of the Medical, Dental, and Optometric Societies present for a weekend conference. One course on Newborn and Premature Care for hospital nurses was given.

Continued midwife control reduced the active midwives to 464. Ten years ago, active midwives totaled 1,403. The Nutrition Service provided diets for patient instruction to 86 Arkansas physicians on a continuing basis and supplied 8 new physicians with copies of the Arkansas Diet Manual. Senior medical students in five groups of about 12 each are given a week's unit of lectures, demonstrations, and field visits in the State Health Department, and the three Departments in Pulaski County.

Division of Tuberculosis Control

A total of 185,220 individuals were X-rayed in mass chest X-ray surveys conducted by the Tuberculosis Control Division. Of these 1,367 were judged to have abnormal findings requiring attention of family physicians; 645 were classified as tuberculosis suspects, and 722 were suspected of other chest pathology. Survey activity resulted in 364 diagnosed cases of tuberculosis; there were 1,618 newly-reported cases from all sources. The Central Case Register contained active records of 12,892 tuberculosis patients requiring supervision. Although incidence and prevalence showed little change, the relatively high tuberculosis death rate continued to decrease.

There is need to restore services of a third mobile X-ray unit. An Act (161) of the 1955 legislature, providing for enforced legal isolation of certain recalcitrant tuberculosis patients, should assist in reducing spread of the disease.

Division of Venereal Disease Control

During the calendar year 2,509 previously untreated syphilis cases were reported to the Venereal Disease Control Division. In the same period 2,529 individuals were reported to have acquired gonorrhea. This represents a substantial increase in both diseases as compared to the previous year, and largely reflects a more intensified case-finding program based upon

- a) contact interviewing and investigation, and
- b) a return to selective mass blood testing.

These measures, together with prompt and effective treatment, have been generally successful in breaking chains of infection and in tending to reduce the reservoir of asymptomatic untreated cases.

The continuing high positivity rates in selected population groups as well as several small localized outbreaks of early infectious syphilis during the past year, emphasize the need for renewed interest in venereal disease control.

Bureau of Local Health Services

The minimal number of full time professional personnel necessary to maintain minimal adequate health services throughout the state is still far below the required number. In order to maintain these services from the standpoint of professional personnel, at least 12 additional medical directors, 150 graduate nurses and 24 sanitarians are needed.

As of December 31, 1955, the seventeen district health departments, the two full-time city health departments, and eight county health departments were employing

- 7 health officers
- 102 graduate or public health nurses
- 1 health educator
- 56 sanitarians
- 87 clerical workers.

The present reasons for existing inadequate local health services are the same as they have been in preceding years. The protection of the health of our people is a moral obligation of the state, city and county; if we ever hope to maintain an adequate number of local health units rendering reasonable and adequate health services, additional funds to support the program and services must be made available.

Heart Disease Control

A small annual federal grant-in-aid allotment is received by the state for heart disease control. No state or local funds are available for this purpose. Practically all of the federal allotment is expended in the support of the cardiac teaching clinic at the University of Arkansas School of Medicine.

Through this clinic many services have been provided for indigents which they could not have obtained otherwise. Some 2,400 patients or potential patients received more than 3,000 clinical services.

The Division of Heart Disease Control also cooperates with the Arkansas Heart Association and local medical societies in conducting local heart and rheumatic fever clinics throughout the state.

Mental Health

The State Health Department continued its participation in the all-purpose out patient mental hygiene clinic in the University of Arkansas School of Medicine. Practically all of the small federal grant-in-aid allotment was expended on the clinic to provide salaries for one psychiatrist, one clinic psychologist and two clerical workers.

The department also purchases limited numbers of accepted pamphlets on mental health for distribution, and motion picture films for loan to interested groups as an educational service.

Dental Health

During the year the eating habits of school children were studied in the Atkins, Clarksville, Osceola and Victoria areas followed by dental health education programs being established in those areas. Pre-fluoridation examinations in cooperation with the Arkansas State Dental Association were conducted in the Harrison and Camden areas.

During the 1955 Arkansas Stock Show the teeth of approximately 1,000 school children were X-rayed. Eight new communities started fluoridation of their water supplies.

The department has suffered a keen loss in the premature death of the Dental Director, H. Shirley Dwyer,

D.D.S. Efforts are being made to fill this vacancy to carry on the program which he so ably established.

Division of Public Health Nursing

Accomplishments

1. A scholarship for a year's study in public health nursing was granted to three local nurses.

2. Eleven (11) new nurses were employed during 1955; (12 resigned) 62 of the 75 counties have at least one nurse.

3. More assistance extended to local nurses through generalized and specialized supervision, particularly in tuberculosis nursing, due to the addition of a qualified tuberculosis consultant nurse.

4. Local public health nurses have showed improvement in planning and carrying out their work programs; securing local cooperation; determining their own areas of interest and needs for in-service education programs.

Needs

1. Better salary to attract better qualified nurses for public health work.

2. Adequate plan to assist nurses in purchasing and operating their personally-owned cars for this work.

3. Ten new supervisors and one mental health consultant are immediate needs.

Division of Public Health Education

Because of lack of educational personnel, the Division of Public Health Education has given first priority in services to those activities which are uniquely educational. Hence, major emphasis has been placed on the acquisition, organization, and utilization of educational equipment, and materials.

Probably the most valuable single contribution to the health education of the public was through the film library—with over 5,000 showings of health films scheduled during the year. Plans are well along for going on television with health films on a regular and continuous basis. This program promises much for the future in terms of motivating the people to care for their own health.

Division of Hospitals

During 1955, the Division of Hospitals licensed 153 hospitals and 64 nursing homes. The annual revision of the State Plan for the Construction of Hospitals and Related Facilities was made, as required under the Federal (Hill-Burton) Hospital Construction Program. A survey of the medical facilities in the state was made and the annual State Plan was expanded to include this new category. Under the provisions of the Hill-Burton Act, Medical Facilities include Nursing Homes, Diagnostic and Treatment Centers, Rehabilitation Facilities, and Chronic Disease Hospitals.

Three hospital projects under the Hill-Burton Program were completed during 1955. Funds have also been allocated, and planning done, on six Hospital Projects, two Nursing Home Projects, and one Diagnostic and Treatment Center Project. Construction is scheduled on these projects early in 1956.

Bureau of Laboratories

The Bureau of Laboratories had a good year in 1955. A staff of twenty received, examined and reported 331,885 examinations (up 20%) on 181,598 specimens (up 14%).

For the first time in the history of the laboratory a fiscal year passed with no positive cultures for diphtheria. On

the other hand, 17% of all sputums received for the diagnosis of active tuberculosis were positive either on direct examination or by culture. There was a marked decrease in the number of animals with rabies and an increase in the number of febrile agglutination tests showing significantly high titers for Paratyphoid B. Consequently, typhoid-paratyphoid (TAB) vaccine is again being stocked for distribution.

Sometime during 1956 the laboratory hopes to add to its services the complement-fixation tests for the more common systemic fungous diseases.

Bureau of Sanitary Engineering

Water

Major improvements were made to 42 public water supplies at a cost of approximately \$3,000,000. Three towns constructed public water systems this year, bringing the total number of public supplies to 216. These supplies serve approximately 45% of the population of the state. Plans for improvements and water plant operation are checked by engineers of this Bureau to assure the safety of the supply.

Swimming Pools

Fourteen public swimming pools were constructed according to plans approved by this Division. This makes a total of 105 pools in the state under the supervision of the State Health Department.

Sewerage

Approximately \$4,250,000 was spent for public sewerage treatment plants and improvements to prevent pollution of our streams and lakes. One hundred and thirty-six public sewerage systems now serve approximately 33% of the state's population.

Plumbing

Dangerous plumbing installations have been further reduced by the enforcement of the State Plumbing Code and the licensing program. Licenses were issued by the Division, by either renewal or examination, to 874 Master Plumbers and 846 Journeyman Plumbers. Nine hundred and fifty-five plumbing inspections and 248 re-inspection were made to determine compliance with the State Code. Fifty-two sets of school or other public building plumbing plans were approved.

Food and Drug

The major activity of this Division was directed toward the enforcement of laws pertaining to habit-forming drugs and the removal of foods unfit for human consumption from commerce. Approximately 28,000 pounds and 42,000 cans or jars of food—including flour, meal, cereals, candy, olives, fruits, flavoring, vegetables, meat, and shortening, were condemned as unfit for human consumption.

Dairy Products

A total of 709 licenses was issued by the Division of Dairy Products in accordance with the state laws, on cream stations, cheese plants, milk condenseries, butter plants and ice cream plants. Periodic inspections have been made of the above plants to insure the production of a clean and healthful product. Dairy products found to be unfit for human consumption by laboratory analysis and inspection, were condemned and removed from sales channels.

Milk

Approximately 25,000 gallons of milk certified daily by the Milk Control Division are shipped into other states.

Inspections were made of 1,522 dairy barns, 78 pasteurization plants, and 42 new dairy barns. Sanitary surveys were made of 24 milk sheds to determine compliance with the state laws and United States Public Health Service Standard Milk Ordinance.

Insect Vectors

Mosquito and fly control programs were conducted in 13 counties at a total cost of \$41,000. Seven thousand six hundred (7,600) premises and 1,900 outbuildings received the spraying service. Twenty-four towns conducted larvicide and/or adulticide programs at a total cost of \$50,000. No Federal or State funds were used in these programs which were financed by County Courts, municipalities and local sources. Technical advice, supervision, promotion of these programs, and loan of equipment was furnished by the State Health Department.

REPORT OF THE ARKANSAS STATE
MEDICAL BOARD

JOE VERSER, Secretary

The Secretary of the Arkansas State Medical Board makes the following report of the activities of this Board since the last meeting of the Arkansas Medical Society:

The 1955 Legislature abolished the three existing Boards, namely, the State Medical Board of the Arkansas Medical Society, the Arkansas Eclectic Medical Board and the Arkansas Homeopathic Board, and created one State Medical Board.

The new Board was organized March 17, 1955, with the following members: Dr. G. D. Murphy, Jr., Dr. M. L. Harris, Dr. Joe Verser, Dr. H. J. Hall, Dr. Frank M. Burton, Dr. Jeff Baggett, Dr. C. H. Young, Dr. Wm. A. Snodgrass, Jr., and Dr. J. Max Roy.

The following officers were elected: Chairman, Dr. G. D. Murphy, Jr.; Vice-Chairman, Dr. M. L. Harris; and Secretary-Treasurer, Dr. Joe Verser. Eugene R. Warren was appointed attorney for the Board.

During the past year the license of one physician was revoked because it was determined that the license was obtained by fraud. The validity of the license of another physician is now being investigated and action will be taken in the near future.

The Board investigated every case of violation of the Medical Practice Act reported to the Secretary during the year. One Court conviction was obtained and one case is now pending.

The Board plans to sponsor new legislation in the hope that these cases can be more adequately prosecuted. The Board and its attorney, Mr. Warren, believe that a more adequate law is necessary and would be another step toward an ideal Medical Practice Act.

A yearly financial report of the Board's activities, as prepared by Winter, Johnson & Company, C.P.A. Accountants, was sent to and approved by the Council of the Arkansas Medical Society.

Following is a report of the Board's proceedings—February 1, 1955 - February 1, 1956:

Physicians registered for 1956:	
Resident	1,421
Non-Resident	584
Physicians licensed by examination.....	83

Physicians licensed by reciprocity	35
Physicians certified to other states	90
License revoked for non-payment of annual registration fee	Incomplete
License suspended for non-payment of annual registration fee	Incomplete
Physicians placed on probation for violation of Federal Narcotic Act	3
Court convictions obtained for violation of Medical Practice Act	1
Cases pending for violation of Medical Practice Act	1
License revoked	1

Following is a financial report covering the period—February 1, 1955 - February 1, 1956. A yearly audit by a Certified Public Accountant will be made in June, 1956:

Cash balance in bank—February 1, 1955	\$15,460.60
Bonds—Series E, purchase price	6,000.00

Collections from the following:

Registration fees	\$ 5,762.00	
Reciprocity fees	2,275.00	
Certification fees	1,146.00	
4-year examination fees	540.00	
Final examination fees	650.00	
Primary examination fees	1,035.00	
Duplicate certificates	15.00	
Postage and exchange on checks	3.25	
Directory sales	86.50	
Physical Therapy fees	90.00	
Eclectic Board	419.64	
Homeopathic Board	202.73	12,225.12
Total	\$12,225.12	\$33,685.72

Expenditures:

Salary—Secretary, Assistant, Withholding & F.I.C.A. Taxes, and expense of Board Members	\$ 8,822.04
Attorney's fee, expense and investigations.....	2,832.20
Office rent	180.00
Dues of Federation of State Board of U. S.	50.00
C.P.A. Audit	150.00
Refunds	56.00
Office expense—printing, telephone, postage, stationery, supplies, bond and advertisement	1,657.39
Total	\$13,747.63
Total Expenditures	\$13,747.63
Bonds on hand	6,000.00
Cash balance in bank, February 1, 1956	13,938.09
Total	\$33,685.72

ARKANSAS STATE ADVISORY COMMITTEE
TO THE SELECTIVE SERVICE SYSTEM

GERALD H. TEASLEY, Chairman

The State Advisory Committee to Selective Service has not had any unusual amount of activity during the past year. There have been a few physicians called to active duty and some dentists. In the case of physicians most of the calls have been filled by recent graduates of medical schools after completion of their first year internship. No unduly large calls are expected during the coming year.

LIAISON WITH STATE BOARD OF HEALTH
JOHN T. HERRON, Chairman

This is to advise that no matters have been brought before the Committee on Liaison with the State Board of Health during the past year, and because of this reason this committee has no report on activities to make.

BUDGET COMMITTEE
J. J. MONFORT, Chairman

The Budget Committee respectfully submits the following proposed budget for 1956:

Income	
Membership dues	\$27,500
Journal advertising	21,500
Interest on bonds	262
Annual Session booth income	3,000
Annual Session banquet and registration..	4,500
A.M.A. reimbursement	200
	<hr/>
	\$56,962
Expenses	
Salaries	\$13,375
Journal expense	15,500
Travel and Convention	5,500
Council expense	300
Telephone and telegraph	1,100
Office supplies and expense	950
Postage	1,100
Dues and subscriptions	300
Rent	1,080
Taxes	210
Contributions	400
Annual Session	6,070
Rural Health Committee	500
Public Relations Committee	1,000
Stationery and printing	900
Auxiliary	1,250
Special committees	50
Auditing	125
Miscellaneous	200
Bond premiums and insurance	90
Legal services	1,500
Legal services reserve fund	1,000
Retirement fund	1,375
	<hr/>
	\$53,875

SCIENTIFIC PROGRAM COMMITTEE AND
LOCAL ARRANGEMENTS COMMITTEE
JOE NORTON, Chairman

The 1956 Scientific Program Committee is composed of: John Olson, Fort Smith; John Wood, Mena; Randolph Ellis, Malvern; William Harrell, Texarkana; Samuel Thompson, Little Rock; Frank Kumpuris, Little Rock; Lawrence Zell, Little Rock; Joseph Norton, Little Rock.

This committee has planned for the annual meeting of the Arkansas Medical Society to be held in Little Rock, Monday, Tuesday, Wednesday, April 23, 24 and 25, 1956, at the Hotel Marion and the Robinson Memorial Auditorium.

Generally the program was planned to include a complete scientific program, an expanded commercial, scien-

tific and hobby exhibit program, a golf and skeet sports program, an outstanding social program, a major public relations effort, a recognition of our own University of Arkansas School of Medicine, all in addition to the usual necessary business proceedings of our Society.

The printed program of the 1956 meeting is considered a part of this report. The committee was aided by many friends over the State, too numerous to mention by name, representing the general practice and specialties, who took the responsibility of securing our outstanding scientific speakers, and arranging our fine luncheon and symposia programs—to all of these men, we express our deep appreciation of their efforts.

The expanded exhibit program was made possible by obtaining the large Robinson Memorial Auditorium Exhibit Hall for our meeting. Paul Schaefer arranged for the commercial exhibits, Lawrence Zell arranged for the scientific exhibits and John McCullough Smith arranged for the hobby exhibits, and we owe them a debt of gratitude for their fine work.

The sports program this year was expanded to include skeet shooting, in addition to golfing—and Elbert Wilkes planned this addition to the usual program, which we think will find immediate favor, and will become a usual part of the annual program. Now you can bring your guns to the meeting!

The social program planned was sponsored by the Pulaskee County Medical Society, and was arranged by Willie and Gordon Oates, which insured its success—to them we are all grateful.

We had hoped to have a telecast of the Ciba Pharmaceutical Co., Inc.'s show, MEDICAL HORIZONS, from the stage of the Robinson Memorial Auditorium, featuring our State medical meeting. This was arranged principally by Bob Robins of Camden, and much work had been done when we were notified in February, 1956, that the Ciba Company could not go through with the program as planned. We are terrifically sorry that this could not come about this year, but we wish to express our thanks to Bob Robins and to the Ciba Pharmaceutical Company, Inc., for the tremendous amount of time and effort spent in planning—we still hope that we can arrange such a program in the future. To replace the television show, we have arranged to have a Community Health Fair on Monday night, April 23, and more details of that program will be announced later. Please help us in our plans and by participating in the program during our meeting.

The week of April 22, 1956, is American Medical Education Week, and we are proud to be able to recognize our own Medical School during this meeting by turning over the morning of April 25, Wednesday, to the school. To Provost Lawrason and to the faculty of the School of Medicine, we say thanks for a fine period of instruction and information, which justifies our faith in our own School of Medicine—in its teachers and in its leaders.

In response to numerous requests, we have left the dinner hour of Monday, April 23, open for fraternity, alumni, reunion and private dinners, and we hope that our membership will take advantage of this opportunity.

This Committee also wishes here to express our deep appreciation to each of the individual speakers who paid to all of us the compliment of such excellent preparation of their individual parts of the program, and who presented themselves so ably. We hope that each of them has enjoyed the meeting, and that they will return again to our State.

The work of the Committee was helped in many ways by many members of the Society over the State, who gave advice, who encouraged our work, who assisted with special problems, and who helped to level many of the mountains we made of mole hills—to all of you—and you know how you helped—our thanks.

The following were members of the Local Arrangements Committee of the Pulaski County Medical Society:

Jerome Levy, Little Rock—Public Relations.
 William Snodgrass, Little Rock—Registration.
 Gordon Oates and Willie Oates, Little Rock, Social.
 Elbert Wilkes, Little Rock—Sports.
 Peyton Kolb, Little Rock—Transportation.
 John McCullough Smith, Little Rock—Hobby Exhibit.
 Lawrence Zell, Little Rock—Scientific Exhibit.
 John William Smith, Little Rock—Memorial Service.
 Robert Ross, Little Rock—Special Dinners.
 Merlin Kilbury, Jr., Little Rock—Supplies and Expenditures.
 Bill Dave Stewart, Little Rock—Question and Answer Booth.

Each of these persons did yeoman's service in their assigned job, and we here publicly state that the smooth manner in which this meeting runs is a tribute to their endeavors—thanks so very much to each of them, and to all who worked with them.

And, finally, in addition to the acknowledgments made thus far, mention must especially be made of two others—our President, L. H. McDaniel, of Tyronza, whose tremendous drive, wonderful spirit, and never-failing optimism were a constant source of help, amazement, and inspiration, and our Executive Secretary, Paul Schaefer, Fort Smith, whose great patience, outstanding ability, and unflagging zeal were sufficient to insure that the many details of preparation would eventually be woven into a fine program.

Your Committees have enjoyed their work. We hope that the members of the Arkansas Medical Society will enjoy our efforts.

PUBLIC RELATIONS

DALE ALFORD, Chairman

It is the sincere belief of this committee that the public relations with the people of our own State are better than in many years. This is due to the sincere efforts of each private practitioner to give the best possible medical service to all patients regardless of income; for it is certainly a true statement that the best public relations are made in the physician's office.

In spite of good public relations our senses should never be dulled to the extent that we become oblivious to the opinions expressed in the various communications media, i. e., press, radio, and television. However, we should also be aware of mistaking good "public relations" for good "publicity." Publicity is good for the medical profession if it is good and if it is not seen or heard too often and if it does not convey too frequently to the public the idea that the organization of medicine is not "pushing" its way into all communications media. In a word—good public relations for medicine is good health for the public.

Public relations in organized medicine is concerned also with good relations with our colleagues in the allied arts.

Medical public relations should also be concerned about the encouragement and education that we can give to those who work by our side day after day who do not have any organization or special certification. The Committee on Public Relations has had as its main program for the year the sponsorship and organization of the Arkansas State Medical Assistants Society. Since many of our physicians have questioned the aims and purposes of such an organization, we are incorporating in our annual committee report the Constitution and By-Laws of the Arkansas State Medical Assistants Society so that all members of the Medical Society may study their plan and then vote to approve or disapprove such an organization at the earliest convenience of our Council. This constitution was prepared under the supervision of Dr. Joe Shuffield, who agreed to serve in an advisory capacity to the Legislative Committee. Dr. Shuffield recommends that Article II of this constitution should read as follows: "To unite in an organization those persons who are employed by members of the Arkansas Medical Society, who are in good standing with that Society." The Constitution and By-Laws of the Medical Assistants Society composes the remainder of this report.

CONSTITUTION AND BY-LAWS OF THE ARKANSAS STATE MEDICAL ASSISTANTS SOCIETY

Article I. Name of Society

The name and title of this organization shall be the Arkansas State Medical Assistants Society.

Article II. Purposes of the Society

(a) To unite in an organization those persons who are employed by members of the Arkansas Medical Society; technical and administrative employees of the medical hospitals and medical laboratories licensed and approved by the Arkansas State Board of Health; technical and administrative employees of the County, City and State Health Departments.

(b) To inspire its members to render honest, loyal and more efficient service to the profession and to the public which they serve.

(c) To render educational and informative services to its members.

Article III

This organization is declared to be non-profit. Any member attempting to affiliate this Society with any union automatically forfeits membership.

Article IV. Component Societies

(a) Component Societies (local groups) may be formed in any locality (City, County, adjoining Counties) where there is sufficient number of eligible members to fill all offices.

(b) In any locality where an Arkansas County and an adjacent county in another State (such as Miller-Bowie Counties) have a common medical society, the medical assistants in that area may form a Component Society. Eligibility for membership, office holding, etc., shall be the same as for the doctors' medical society.

Article V. Membership

Membership shall be of three types:

(a) Active: Active members shall be those actively employed as shown under (a) Article II.

(b) Associate: Associate members shall consist of those who have been active members for at least two years and have not left the medical profession for other fields of endeavor. They are accorded all privileges except voting and holding office.

(c) Honorary: This membership may be conferred upon one or no more than two, persons in any one year at the annual meeting by a majority of votes cast. This membership is conferred on those who have been active in furthering the welfare of this Society. The nominations shall be made to, and approved by, the House of Delegates prior to presentation to the Society. Members pay no dues, and are without the right to vote.

(d) Reinstatement: See By-Laws (Article VI-e).

Article VI. House of Delegates

The House of Delegates shall be the legislative body of the Society, and shall consist of (1) Delegates elected by the Component County Societies; (2) Members of the Advisory Committee; (3) Members of the Executive Committee, and (4) Ex-officio, the President, President-Elect, Secretary, Treasurer, and past presidents of the Society, provided, however, that the ex-officio members shall have the power of voting on all subjects except the election of officers.

Article VII. Council

The Council shall consist of the Councilors, the President, President-Elect, Secretary, and Treasurer. Past Presidents shall be members ex-officio, without the right to vote. A majority of the voting members shall constitute a quorum.

Article VIII. Meetings

The annual meeting shall be held in the spring of the year, preferably in the same city as the annual meeting of the Arkansas Medical Society. Meetings may, however, be held upon invitation of Component Societies in any locality.

Article IX. Officers

Officers of this organization shall be: President, President-Elect, Secretary and Treasurer. Election of officers shall be held at the annual meeting. With the exception of the Secretary, the term of office shall be one year, and one year must elapse before re-election to any office. The Secretary may be elected to serve as many consecutive terms as desirable. The President-Elect shall assume office of the presidency at the close of the annual meeting.

Article X. Advisory Committee

At the beginning of each term of office, the President shall request the President of the Arkansas Medical Society to appoint an Advisory Committee consisting of three doctors. The Executive Secretary of the Arkansas Medical Society is to be a permanent member of this Committee. This Committee shall be consulted on any vital issues of the Society where it is obvious that approval of the Arkansas Medical Society is necessary before action can be taken. This Committee shall serve as a liaison agency with the Council of the Arkansas Medical Society.

Article XI. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall have been submitted in writing to all active members thirty days prior to the meeting. Any amendment becomes effective immediately upon adoption.

BY-LAWS

Article I. House of Delegates

Section 1. The House of Delegates shall meet in January preceding the annual session, and shall be called into session at any time by the President.

Section 2. Each Component Society shall be entitled to send to the House of Delegates each year one delegate for every 15 members who are paid up and in good standing.

Section 3. A majority of the House of Delegates registered shall constitute a quorum.

Section 4. It shall, through its officers and otherwise, give diligent attention to the work of the Society, and shall constantly study and strive to make each annual session a stepping-stone to future ones of higher interest.

Section 5. It shall use its influences to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 6. It shall make careful inquiry into the possibilities of the Society in each county of the State, and shall have authority to adopt such methods as may be deemed efficient for building up and increasing the interest in such component societies as already exist, and for organizing the society in counties where the society does not exist. It shall especially and systematically endeavor to promote friendly intercourse among medical assistants of the same locality, and shall continue these efforts until every reputable and eligible person has been brought under the medical assistants society influence.

Section 7. It shall elect representatives to the House of Delegates of the American Medical Assistants Society in accordance with the constitution and by-laws of that body (if and when it is organized).

Section 8. It shall divide the State into councilor districts, specifying what counties each district shall include, and when the best interest of the society will be promoted, thereby organizing in each a District Medical Assistants Society, and all members of component county societies shall be members in such district society.

Section 9. It shall have authority to appoint committees for special purposes from among members of the society who are not members of the House of Delegates, and who are in good standing with the society. Such Committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

Section 10. In case of vacancy in the office of a delegate, the House of Delegates shall have the authority to seat any member of that County Society in attendance at said meeting as delegate, with full right to perform all the duties of that office.

Article II. Council

Section 1. The Council shall meet on the first day of the annual session and daily during the session and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall meet on the last day of the annual session of the society to organize and outline the work for ensuing year. It shall elect a Chairman. It shall, through its chairman, make an annual written report to the House of Delegates.

Section 2. Each councilor shall be organizer, peacemaker and censor for his District. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the Society; and for improving and increasing the zeal of the component societies and their members. The Councilor shall be prepared to make an annual written report of her work, and of the condition of each society in her district, at the annual ses-

sion of the House of Delegates. The necessary traveling expenses incurred by such Councilor in the line of the duties herein imposed may be allowed, after being submitted in itemized statement form, but this must not be construed to include his expenses in attending the annual session of the Society.

Section 3. The Council shall be the executive body of the House of Delegates and between annual sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws. It shall consider all questions involving the right and standing of members, whether in relation to other members to component societies, or to this society. All questions of an ethical nature brought before the House of Delegates or the general meeting, shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of Component Societies, on which an appeal is taken from the decision of an individual councilor.

Section 4. The Council shall have authority to organize the medical assistants of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 5. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary. All money received by the Council and its agents, resulting from the discharge of the duties assigned to them, must be paid to the Treasurer of the Society. It shall annually audit the accounts of the Treasurer and Secretary and other agents of this society and present a statement of same in its annual report to the House of Delegates, which report shall also specify the character and cost of all the publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary. In the event of a vacancy in the office of the Secretary or of the Treasurer, the Council shall fill the vacancy until the next annual election.

Article III. Election of Officers

Section 1. Immediately after adjournment of the first meeting of the House of Delegates at each annual session, the Delegates from the Component Societies shall meet. They will select one delegate from each District to form a nominating committee. This Committee shall consist of ten delegates, one from each councilor district. It shall meet and select a Chairman and a Secretary. It shall be the duty of this Committee to consult with the members of the Society and to hold one or more meetings at which the best interest of the Society for the ensuing year shall be considered. The Committee shall report the result of its deliberations to the House of Delegates in the form of a Ballot, containing the names of two or more members for the office of President-Elect, and not more than the names of two members for the other offices to be filled at the annual session. No two candidates for President-Elect shall be named from the same county.

Section 2. All elections shall be by ballot, and the majority of the votes cast shall be necessary to elect.

Section 3. The report of the Nominating Committee shall be the first order of business of the House of Delegates on the afternoon of the last day of the annual session.

Section 4. The election of officers shall be the second order of business of the House of Delegates on the afternoon of the last day of the annual session.

Section 5. Any person known to have solicited votes from or sought any office within the gift of this Society shall be ineligible for any office for two years. No member shall be eligible for any office of this Society who is not in attendance at the meeting at which the election is held.

Section 6. In the event of the death or removal of the President-Elect, the nominating committee, selected at the preceding annual convention, shall meet immediately for the purpose of filling such vacancy. The nominating committee shall prepare in ballot form, the names of two or more members, who are in good standing with the Society, which ballot will be sent to members of the House of Delegates, who will be asked to cast their vote, and mail the ballots back to the Secretary of the Nominating Committee. When all of the ballots have been received, the Nominating Committee shall meet. The majority of the votes cast shall be necessary to elect the president-elect.

Article IV. Duties of Officers

The duties of the officers shall be such as is implied by their respective offices and consistent with standard parliamentary procedure.

President: Shall preside over all meetings and shall appoint such committees as are deemed necessary for the activities of the Society.

President-Elect: Shall substitute for the President in the absence of the President, and shall succeed to the Presidency.

Secretary: Proceedings of all meetings, annual and executive, shall be kept in a proper book. Within five days of such meetings copies of proceedings shall be sent to each member of the Executive Committee. The Secretary shall keep a roster of the members; shall conduct all correspondence relating to the Society, and shall issue notices of meetings.

Treasurer: All monies shall be paid to the Treasurer, who shall pay out money only upon original bills and vouchers signed by the President. The Treasurer shall make an annual report of the condition of the Treasury, and shall be bonded to cover the amount entrusted, the cost of said bond being paid out of the Treasury of the Society. The accounts of the Treasurer shall be completed, audited, and placed in the hands of the new Treasurer in 15 days following the close of the annual meeting.

Historian: See Article V under Publicity.

Committees: The incoming President shall appoint committees deemed necessary for the activities of the Society. Appointments shall be ratified by the Executive Committee. Committee Chairmen shall make reports of committee proceedings at annual meetings and submit these reports in writing.

When going out of office each officer will personally instruct and acquaint the incoming officer as to their duties, and of any unfinished current activity so that the functions of the Society may continue without interruption.

Article V. Standing Committees

Membership: Shall consist of a chairman and four members, appointed by the President to serve for one year. It shall be the duty of this committee to receive and pass on applications for membership and shall send certification of same to each member. This committee shall use its best

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efforts to induce any person qualified for membership to become a member of the Society.

Convention: Committee shall consist of a chairman and two members appointed by the President to serve for one year. Members of this committee shall reside in the city (or close vicinity) where the annual meeting is to be held. The Chairman shall appoint as many other members as is deemed necessary for proper functioning of the committee. They shall make all arrangements for the annual meeting, including the program and speakers. All correspondence pertaining to the Convention shall be handled by this committee and completed two weeks after the annual convention. After the payment of all bills for expenses incurred in connection with the annual meeting the Chairman of the Committee shall submit a full financial report to the President and forward all remaining money to the Treasurer. This should be done within thirty days after the date of the meeting.

Publicity: Shall consist of a chairman and two members appointed by the President to serve for one year. This Committee shall send notices of annual meetings to the Journal of the Arkansas Medical Society and local county bulletins. It shall be responsible for all releases to the press which have been approved by the Council of the Arkansas Medical Society. The Chairman of this committee shall also serve as Historian and shall keep in scrapbook form notices and newspaper clippings, programs from annual meetings and any other articles of interest.

Article VI. Dues

(a) Dues for active members shall be \$2.00 per year, or part thereof.

(b) Dues for associate members shall be \$1.00 per year.

(c) Honorary members shall be exempt from dues.

(d) Such dues shall be payable to the treasurer at the time of application submitted by new members, and January 1st for standing members.

(e) Members whose dues have not been received by January 31 will be dropped from the membership roll. A member may be re-instated at any time upon payment of delinquent dues, provided the member still meets all requirements for membership.

Article VII. Expenses of Officers

Full expenses of the President are paid to all meetings, including lodging, meals and transportation. The expenses of other officers shall include transportation and meals only. Automobile travel of 5c per mile will be allowed.

Article VIII. Order of Business

1. Call to order by president.
2. Reading of minutes of last meeting.
3. Report of Executive Board.
4. Report of Treasurer.
5. Report of Committees.
6. Unfinished business.
7. New business.
8. Adjournment.

Article IX. Rules of Order

All parliamentary procedure and all matters not covered in the Constitution or By-Laws shall be subject to Robert's Rules of Order.

Article X. Quorum

At any regular or special meeting of this Society, representatives of a majority of component societies shall con-

stitute a quorum, authorized to transact any business duly presented.

At any meeting of the executive committee, a majority of the committee shall constitute a quorum.

Article XI. Code of Ethics

The Code of Ethics shall be as set forth in the Oath of Hippocrates, and the Code of Ethics of the American Medical Association. The Medical Assistants should be morally, mentally, and physically clean, honest in their dealings and loyal to their employer. Their responsibility to their fellows should conform with the honor and dignity expected of a cultured person. Discussion of wages, incidents of a private nature, financial status of an employer will be considered unethical.

Article XII. Amendments

The By-Laws may be amended at any annual meeting by a two-third vote of all members present, the proposed amendment having been submitted in writing to all members thirty days prior to the meeting. Any amendment becomes effective immediately upon adoption.

SUB-COMMITTEE ON STATE HEALTH AND MEDICAL RESOURCES FOR CIVIL DEFENSE

JOSEPH A. BUCHMAN, Chairman

Civil Defense activities do not carry much interest in this section of the country. However, plans are being drawn to devote a part of one issue of the State Medical Journal to Civil Defense articles.

The State Civil Defense program is under the directorship of Mr. Owen Payne, Jr. The equipment for a 250-bed hospital has been acquired and at the present time is stored in the Little Rock area. It is hoped that a part of this emergency hospital can be shown at the State Medical Meeting.

REPORT OF THE EXECUTIVE SECRETARY

PAUL C. SCHAEFER

The Arkansas Medical Society is growing. At the end of 1955, there were 1,112 dues-paying members, 75 affiliate, and 65 life members, for a total active membership of 1,252. 1,082 members from Arkansas are also members of the American Medical Association.

In 1955, for the first time, the roster of the Society, published with the December Journal, carried the street addresses and telephone numbers of each member. We are happy to acknowledge the assistance of the Southwestern Bell Telephone Company in this project to make the roster more useful.

In order to prevent the possibility of their loss by fire, the current membership record cards were microfilmed and the film placed in the Society's safe-deposit box. The program of microfilming of the records of the Society will be expanded in the future to guarantee their existence.

The Executive Secretary wishes to take this opportunity to thank the county society secretaries for their cooperation in improving county society reports and dues collections and for getting them in earlier each year.

MEDICAL ARBITRATION COMMITTEE

INDUSTRIAL HEALTH COMMITTEE

Arkansas Medical Society

Arkansas Adjusters Association

Little Rock Claim Managers Council

- A. Disputes between members of the Arkansas Medical Society and the Insurance Claim Adjusters over bills, "lifting cases," and the like no longer need to result in unfavorable publicity and ill feelings.

In 1953 the State Medical Society adopted an Arbitration Plan which had been worked out between the Industrial Health Committee of the State Medical Society, the Little Rock Claim Managers Council, and the Arkansas Adjusters Association.

Although the Workmen's Compensation Commission had judicial authority over injury cases arising out of and in the course of employment, it was the opinion of those who were working on this problem that doctors and claim adjusters prefer to settle their own differences between themselves.

The agreement which established the Arkansas Medical Arbitration Commission is as follows:

1. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the jurisdiction control of the attending physician.
2. Mediating, if possible, those cases wherein the insurance companies complain that the attending physician has neglected to furnish adequate medical reports.
3. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the proper committee of the State Medical Association.
4. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.
5. That both the physician and insurance carrier involved are and must be bound by the decision of the joint Arbitration Committee.
6. That such an arbitration committee shall consist of three physicians duly designated by the State Medical Association as regular members and one physician as an alternate who would serve at the request of the Chairman in the event that one of the regular members was disqualified for any reason; and two representatives of the insurance industry duly designated by the Arkansas Claim Managers Council as regular members and one representative as an alternate who would serve at the request of the Chairman in the event that one of the regular members was disqualified for any reason. A majority decision of three of the five members shall be final and binding on both parties.
7. In the event of complaints from either the insurance carriers or physicians, where the arbitration committee is unable to agree, it may appoint a special committee to investigate and report back to the arbitration committee recommendations as to the action to be taken in the specific case under consideration. Such special committee shall be made up of members outside of the locality from which such a complaint arises.

- B. For reasons that are readily apparent it was not considered feasible to operate this arbitration agreement without making some modification. After several conferences it was determined that the President of the Society would designate one physician from each medical district who would participate as a member of the medical arbitration commission. The Little Rock Claim Managers Council named two regular members and two alternate members to work with the members from the Medical Society in establishing the final machinery.

The Medical Society named Dr. R. C. Shanlever, Jonesboro; Dr. T. L. Adair, Bald Knob; Dr. J. Max Roy, Forrest City; Dr. George B. Talbot, Pine Bluff; Dr. A. D. Cathey, El Dorado; Dr. N. B. Daniel, Texarkana; Dr. Thomas M. Durham, Hot Springs; Dr. Joseph A. Buchman, Little Rock; Dr. D. L. Owens, Harrison; and Dr. John D. Olson, Fort Smith.

The Little Rock Claim Managers Council named B. M. Magar, Claim Manager, Liberty Mutual Insurance Company, and A. R. M. Mitchell, Claim Manager, Hartford Accident and Indemnity Company, as regular members with Mr. George Wesendonk, Employers Mutual of Wassaw, and Mr. J. C. Monan, Claim Manager, Fidelity and Casualty Company, as alternates.

- C. As a result of conferences between these members it was agreed that the designated representative of the State Medical Society would serve as Chairman of the Arbitration Commission for any dispute which arose in his district. A representative of the Insurance Industry would serve as Secretary and handle all of the necessary correspondence. Two other physicians from the Medical District in which the dispute arose would be designated by the General Chairman and they, with the designated representative of the Society from that District, would represent the Society as members of the Arbitration Commission for that particular dispute.

This plan would eliminate the necessity of any doctor going beyond his own Medical District to serve as a member of this Commission. Because of his accessibility to the Workmen's Compensation Commission, from whom it was anticipated that disputes would be referred, it was considered practical that the General Chairman, representing the State Medical Society, would be the designated physician from the Little Rock District.

The Workmen's Compensation Commission may refer a dispute between a doctor and an insurance company direct to the General Chairman. Any insurance company or doctor who wishes the Commission to mediate a dispute in which he is involved may make the request either to the Commission or the General Chairman.

- D. The Commission adopted the following rules for Medical Arbitration:
1. A request for Medical Arbitration may be made to either the General Chairman or Secretary of the Medical Arbitration Commission.
 2. Any person submitting a case for arbitration must show that a sincere effort has been made to compose the differences involved.
 3. The delegate from the Medical District in which the dispute arises shall serve as Chairman for the dispute in his district. The other two doctors will be designated by the General Chairman.
 4. No technical rules of evidence are to be followed. Commission may accept any evidence submitted and may rely on its own knowledge and experience in reaching its decision.

5. A written opinion will be furnished to each party to the dispute and to the Workmen's Compensation Commission.
 6. This Committee is to arbitrate on doctor's fees or a clinic's fees when a clinic is owned by the doctor named, but not the bill of independent hospitals.
- E. The fact that only five cases have come before the Arbitration Commission for the years 1954 and 1955 is ample evidence that it will not become time-consuming for anyone. It is also indicative of the fact that most physicians and insurance carriers are anxious to compose their own differences, and the existence of the machinery to arbitrate their disputes is an added incentive for them to work out their disputes without the necessity of submitting them to arbitration.

A careful review of the five cases passed upon in this two-year period discloses two basic reasons for the dispute having arisen.

Almost without exception, the attending physician failed to give the insurance carrier a comprehensive report of the condition of the patient and the treatment involved so that the insurance carrier could be fully aware of the services rendered. The insurance carrier was usually content to wait for the information from the physician without making a sincere effort to learn just what treatment was actually being rendered.

Three of the decisions of the Arbitration Commission resulted in an approval of the fee submitted by the physician, and two of the decisions effected a reduction in the bill submitted.

The Workmen's Compensation Commission requires insurance carriers to file medical reports and medical bills. In addition to the requirement that these medical reports be filed with the Commission, the insurance carrier needs medical reports so that it may intelligently establish reserves for those cases. Most physicians treating industrial cases are aware of this requirement.

The physician treating an industrial case is usually aware, also, of the fact that a complete and compre-

hensive report of the condition of the patient and the treatment rendered is calculated to reduce to a minimum the possibility of his having a dispute with the insurance carrier over his remuneration.

Conclusion

We believe that the results thus far obtained by the Medical Arbitration Commission is ample proof of its success and that each of you will continue to endorse it and give it your complete support.

AMERICAN MEDICAL EDUCATION FOUNDATION

W. R. BROOKSHER, Chairman

The fifth annual meeting of state chairmen of the American Medical Education Foundation was advised that the medical schools of the United States need aid in the amount of ten million dollars and hope was expressed that two million dollars of this amount might be raised in the 1956 campaign. That there is a crisis in medical education from a shortage of funds is all too apparent. Physicians have a great responsibility in making both a liberal response and in securing additional contributions from outside the medical profession if these financial shortages are to be relieved. Already three privately-endowed medical institutions have been forced to seek the tax rolls for their continued operation. Unless physicians and the public realize that if private funds are not forthcoming, there will rise an insistent demand for Federal funds to support continuing medical education.

In Arkansas the practical benefit of the American Medical Education Foundation has been shared by the University of Arkansas School of Medicine. The grant for 1955 was \$25,614.00, and the total grant in the years 1951-55 has been \$108,652.00. But a negligible portion of these amounts have been contributed by Arkansas physicians.

You are urged to contribute annually and liberally.



PROGRAM
EIGHTIETH ANNUAL SESSION
ARKANSAS MEDICAL SOCIETY

Little Rock — April 23-25, 1956

SUNDAY, April 22

REGISTRATION—2:00-4:00 P. M.—Lobby of Hotel Marion.

SPECIAL TELEPHONE SERVICE will be maintained at the registration desk. PHONE NUMBER—FRanklin 2-0149.

AMERICAN CANCER SOCIETY PROGRAM—To be announced later.

MONDAY, April 23

EXHIBITS open from 8:00 A. M. to 5:00 P. M.—Exhibit Hall, Auditorium.

GOLF TOURNAMENT—Little Rock Country Club.

GENERAL SESSION

Lecture Hall, Auditorium

John Olson, Fort Smith, presiding

- 9:00- 9:20 INVOCATION; PRESIDENT'S ADDRESS—L. H. McDaniel, Tyrnza.
- 9:25- 9:45 LEO E. BROWN, Director, Department Public Relations, American Medical Association.
- 9:50-10:10 DR. R. L. SANDERS, Past-President, Southern Medical Association.
- 10:15-10:35 MEDICINE—Julian Ruffin, Duke University, "Peptic Ulcer."
- 10:35-11:00 VISIT EXHIBITS.
- 11:00-11:20 MEDICINE—Robert Huseby, University of Colorado, "Palliative Medical Therapy of Carcinoma of the Breast."
- 11:25-11:45 RADIOLOGY—John Hope, Philadelphia, "The Normal Chest of Infants and Children—Facts and Fallacies."
- 11:50-12:10 GENERAL PRACTICE—R. A. Davison, University of Tennessee, "Teaching General Practice in the Medical School."
- 12:30- 2:00 LUNCHEONS, Hotel Marion—
MEDICINE—Banquet Hall, Wilburn Hamilton, Little Rock, presiding:
Elmer Purcell, University of Arkansas, "Fever of Undetermined Origin."
RADIOLOGY—Coach Room, George Burton, El Dorado, presiding:
Business Session.
- 2:00- 4:00 SYMPOSIA—
ARKANSAS ACADEMY OF GENERAL PRACTICE—Lecture Hall, Auditorium, Ben Saltzman, Mountain Home, presiding:
R. A. Davison, University of Tennessee, "The Relation Between General Practitioners and Specialists."

MEDICINE—Banquet Hall, Hotel Marion, Jerome Levy, Little Rock, presiding:

"Gastrointestinal Bleeding"—Participants: Julian Ruffin, Duke University, Medicine; Joe Hardin, Little Rock, Medicine; Joe Calhoun, Little Rock, Radiology; Peter O. Thomas, Little Rock, Surgery; Grimsley Graham, Little Rock, Surgery.

RADIOLOGY—Coach Room, Hotel Marion, George Burton, El Dorado, presiding:

John Hope, Philadelphia, "The Acute Abdomen in Infancy."

William Snow, Shreveport, "Heart Shadow Study in Inspiration and Expiration."

Marvin Keirns, Memphis, "Peripheral Arteriography."

4:00- 5:00 VISIT EXHIBITS.

4:00- 5:00 HOUSE OF DELEGATES, Lecture Hall, Auditorium.

6:00- 7:30 SPECIAL REUNION, ALUMNI, FRATERNITY, PRIVATE DINNERS.

The Lambda Rho Chapter of Phi Chi will convene as follows at the Banquet Hall of the Hotel Marion:

5:00 P. M.—Cocktails

5:45 P. M.—Dinner

7:00 P. M.—Adjourn to Health Fair

9:00 P. M. to 1:00 A. M.—Dance

5:00- 8:00 HEALTH FAIR—Public Relations Effort—Auditorium:

5:00-7:00—Exhibits open to public, Exhibit Hall.

7:00-8:00—Panel Discussion for Public, Main Hall.

TUESDAY, April 24

GOLF TOURNAMENT—Little Rock Country Club.

SKEET SHOOT—Riverdale Country Club.

EXHIBITS open from 8:00 A. M. to 5:00 P. M.—Exhibit Hall, Auditorium.

GENERAL SESSION

Lecture Hall, Auditorium

William Harrell, Texarkana, presiding

9:00- 9:20 SURGERY—Marvin Johnson, University of Colorado, "Diaphragmatic Hernia."

9:25- 9:45 PEDIATRICS—Clement Smith, Boston, "Why and How to Take Care of Premature Infants."

9:50-10:10 UROLOGY—Harry Spence, Dallas, "A Review of the Kidney Stone Problem."

- 10:15-10:35 OBSTETRICS—Charles Paul Hodgkinson, Henry Ford Hospital, Detroit, "Hypofibrinogenemia."
- 10:40-11:00 SURGERY—George Hollenbeck, Mayo Clinic, Rochester, "Surgical Treatment of Obstructive Jaundice."
- 11:05-11:25 GYNECOLOGY—Willard Cooke, University of Texas, "The Indications for Treatment of Uterine Myomata."
- 11:30-11:50 OPHTHALMOLOGY—A. E. Braley, University of Iowa, "Diagnosis and Treatment of External Inflammation of the Eyes in Infants."
- 11:50-12:20 MEMORIAL SERVICE—John W. Smith, Little Rock, presiding.
Vocalist: Mrs. Wanda Saxon Reynolds.
- 12:30- 2:00 LUNCHEONS—Hotel Marion.
- SURGERY—Banquet Hall, Frank Kumpuris, Little Rock, presiding.
- PEDIATRICS—Rendezvous Room, Vida Gordon, Little Rock, presiding.
- EYE, EAR, NOSE, THROAT—Coach Room, N. B. Burch, Hot Springs, presiding.
- OBSTETRICS-GYNECOLOGY—Colonial Hall, John W. Jones, Texarkana, presiding.
- UROLOGY—Parlor B, Grady Reagan, Little Rock, presiding.
- 2:00- 4:00 SYMPOSIA—
- SURGERY—Banquet Hall, Hotel Marion, Frank Kumpuris, Little Rock, presiding:
Marvin Johnson, University of Colorado, "Arteriovenous Aneurysms."
George Hollenbeck, Mayo Clinic, "Surgical Treatment of Esophageal Varices."
- PEDIATRICS—ARKANSAS ACADEMY OF GENERAL PRACTICE—Lecture Hall, Auditorium, Vida Gordon, Little Rock, presiding:
"Resuscitation of the Newborn"—Participants: Clement Smith, Boston, Pediatrics; Ben Saltzman, Mountain Home, General Practice; Willis Brown, Little Rock, Obstetrics-Gynecology.
- OBSTETRICS-GYNECOLOGY—Colonial Hall, Hotel Marion, John W. Jones, Texarkana, presiding:
Calvin Simmons, Pine Bluff, "Maternal Mortality in Arkansas."
C. Paul Hodgkinson, Detroit, "Pregnancy Following Cardiac Surgery."
Melvin R. McCaskill and Charles P. Wickard, Little Rock, "Experiences in the Use of Chlorpromazine (Thorazine) During Labor and Delivery."
Willard R. Cooke, Galveston, "Dysmenorrhea."
Fred Stone, Stuttgart, and James Mashburn, Fayetteville, "Obstetrical Experiences in General Practice."
- UROLOGY—Parlor B, Hotel Marion, Grady Reagan, Little Rock, presiding:
Harry Spence, Dallas, "Pyelogram Clinic"—presenting interesting or problem films for discussion.

EYE, EAR, NOSE, THROAT—Coach Room, Hotel Marion, N. B. Burch, Hot Springs, presiding:

N. B. Burch, Hot Springs, "Chairman's Address."

Charles S. Lane, Jr., Fort Smith, "Surgical Problems Involved in the Removal of Glomus-Jugulare Tumors."

Harold G. Tabb, New Orleans, "Stapes Mobilization for Restoration of Hearing in Otosclerosis."

Luncheon—Business session.

Max Baldridge, Texarkana, "Pathological Findings in Enucleated Eyes."

A. E. Braley, University of Iowa, "Surgery of the Lacrimal Gland."

4:00- 5:00 VISIT EXHIBITS.

5:30- 7:30 SOCIAL HOUR—Continental Room, Hotel Marion, sponsored by Pulaski County Medical Society, arranged by Gordon Oates, Little Rock.

8:00-12:00 ANNUAL DINNER AND DANCE—Ballroom, Hotel Marion; music by Tommy Scott's Orchestra.

Special Entertainment, arranged by Willie and Gordon Oates, Little Rock.

Awards, Golf Tournament and Skeet Shoot, arranged by Elbert Wilkes, Little Rock.

WEDNESDAY, April 25

EXHIBITS open from 8:00-12:00 Noon—Exhibit Hall, Auditorium. (Exhibits to be dismantled after 12:00 Noon.)

GENERAL SESSION

Lecture Hall, Auditorium

John Woods, Mena, presiding

The week of April 22, 1956, has been designated American Medical Education Week. Therefore, in this spirit, today we are happy to recognize our own University of Arkansas School of Medicine in the morning's program. Due to weather and other conditions, our School of Medicine and University Medical Center cannot occupy the new Medical Center quarters in time for the previously planned noon and afternoon programs. However, it is hoped that you will avail yourselves of this opportunity to ride out to the new Medical Center and look it over. Guides will be available to help you through the buildings.

9:30- 9:50 F. Douglas Lawrason, Provost, Medical Center, "Objectives of Medical Education."

9:55-10:15 James Dinning, Little Rock, "Preparation for Medicine."

10:20-10:40 James Wortham, Little Rock, "The Changing Curriculum"

10:40-11:15 VISIT EXHIBITS.

11:15-11:35 Nelson Evans, Little Rock, "The Role of a University Hospital in Medical Education."

- 11:40-12:00 Dave Gould, Little Rock, "Some New Approaches in Teaching Radiology."
- LUNCHEON.
- 2:00- 3:00 HOUSE OF DELEGATES—Lecture Hall, Auditorium.
- 3:00- 3:30 FINAL GENERAL SESSION—Lecture Hall, Auditorium.

The Scientific Exhibits to be shown at the Robinson Auditorium during our coming Annual Session now include the following:

The role of Sodium Salts and of the acid-base equilibrium in the production and treatment of experimental and clinical edema.....	Samuel A. Corson, Elizabeth Corson
Problems in Vascular Surgery	Harwell Wilson
Physician's Responsibility in Highway Accidents.....	American Medical Association
Pediatric Urology.....	James O. Cooper, Schuler McKinney, Sam G. Jameson
Rhinoplasty.....	H. A. Bailey, Paul Mahoney
Bezoars of the stomach.	George G. Regnier, James Morrison
Common congenital anomalies of the urinary tract.....	Ralph A. Downs
Management of Nasal Allergy	Norman N. Fein
A Dermatologic Clinic.....	Calvin J. Dillaha
Hiatal Hernia in the last trimester of pregnancy.....	Willis Brown, James Atkinson
Maternity Clinic in Midwife Territory....	William B. Harrell, J. R. Ramirez, Juan T. Mallari
Arkansas Joint Committee on School Health.....	State Board of Health
Treatment of Seborrhea Capitis, Seborrhoeic Dermatitis and Pyoderma with Sebizon.....	Arnold H. Gould
The Evolution of Fracture Treatment.....	Kenneth Jones, Horace R. Murphy
Correlation of Areas Visualized by Sigmoidoscopy and Barium Enema.....	W. J. Wilkins, Jr.
Mental Illness and the Family Doctor.....	State Hospital
The Use of Electroencephalography in Practice.....	Frank Padberg
Hypotensive Anesthesia	Joseph P. Hickey
Treatment of Aneurysms and Occlusive Diseases of the Aorta by Surgical Resection.....	Joseph A. Buchman
Gout.....	Guy T. Williams
Value of Orthoptics in Strabismus.....	Dale Alford
L. E. Phenomenon.....	S. Wm. Ross
Diagnosis of Surgical Cardiac Lesions.....	Bill Stewart
Treatment of Surgical Diseases of Infants.....	Frank Kumpuris
Report on Carcinoma of Cervix Treated at South Arkansas Tumor Clinic.....	Joseph Norton, George Burton

Included with the scientific exhibits are two non-medical exhibits:

- Hobby exhibit
- Occupational Therapy

— ★ Editorial ★ —

SAFETY ON THE ROAD

Considerable attention is being given in the past several months by various segments of the American public to the subject of the nation's greatest killer, the moving automobile. The American Medical Association has devoted time and studies in an official way to the problem and many of the members individually, and component medical groups have been leading in the consideration.

When the figures of the National Safety Council are seen and it is realized that more than one hundred people are killed in car accidents every day, the figure becomes astounding and the apparently little that is being done to stop this amount of slaughter becomes appalling. It becomes more appalling when it is pointed out that this number does not include the crippled and disfigured.

Something is being done, however, by the car manufacturers in the way of safety, and the whole problem has been taken up by the American Association of Safety Engineers. Through this organization, movies, charts, information and speakers are available for an attack on this pressing problem.

The Arkansas Chapter of the Association of Safety Engineers is active and has volunteered its services for programs on safety in the local communities. Mr. E. J. Hawkins, whose headquarters are in Little Rock, is chairman of the group which will provide speakers and discussions which are available for Lions Clubs, Home Demonstration Clubs, professional, civic and trade organizations. Mr. Hawkins has said that he is extremely pleased that in some areas his committee has had medical men or medical society sponsorship, and he would welcome such sponsorship in any community.

Here seems to be an area of public service open to the individual physician or society for an attack on the greatest killer of them all.

THE VALUE OF GASTRIC ANALYSIS IN CURRENT PRACTICE

ALFRED KAHN, JR., Little Rock

Gastric analysis is not a popular procedure with either the patient or physician. In certain situations it can be a very important diagnostic ad-

junct. Fentress and Sandweiss (Harper Hospital Bulletin 13, p. 184, November-December, 1955) briefly reviewed its value in relationship to cancer surveys. They point out that X-ray screening methods to detect cancer of the stomach were not rewarding; in one series 5,341 stomachs were examined and only 11 or 0.2% cancers were found, thus costing \$1,068.00 to find each cancer. In contrast, the review indicates that if achlorhydria is present cancer of the stomach on routine survey runs at least 1% and maybe 10% in cases of pernicious anemia. Since a new method of tubeless gastric analysis by measuring the amount of urinary excretion of an ingested dye is becoming available, a better and easier selection of cases for gastric cancer screening by X-ray can be obtained; thus the cost and effort is greatly reduced.

Galambos and Kirsner (Archives of Internal Medicine, Vol. 96, page 752, December, 1955) reported on the use of Segal's method of tubeless gastric analysis using an azure A ion exchange compound. They compared the results in 104 patients of using routine gastric aspirations by a Levine tube to the tubeless method and correctly identified 82 of 84 patients with free HCl, after the stimulant Histalogs; 20 patients with achlorhydria were identified.

The gastric analysis is important in other diagnostic situations. For example, it has been pointed out that duodenal ulcers, bear a close relationship to gastric acidity. Patients with duodenal ulcers almost invariably show excessive gastric HCl; in the absence of HCl the diagnosis of duodenal ulcer is difficult or impossible to sustain. This has been paraphrased by others: "No free HCl, no duodenal ulcer."

Gastric ulcer behaves like a different disease from duodenal ulcer; one of the important differences is that gastric acidity here may be normal or lower than normal. Other causes for diminished or absent HCl include pernicious anemia, hyperthyroidism, vagolytic drugs, infectious disease, gastric cancer, gastritis, etc.

Research in gastric analysis is being pursued along lines that will lead to clinically important material. For example, studies on the intrinsic factor of pernicious anemia have demonstrated its virtually complete localization to the stomach in man. Thus total gastrectomy deprives man of Vitamin B-12 unless it is supplied parenterally. Richmond, Caputto and Wolf (Gastroenterology, Vol. 29, page 1017, 1955) are fractionating the larger molecular substances in gastric juice; when perfected this technique may give valuable insight into pepsin, blood group A substance, in-

trinsic factor, and other important substances.

Gastric analysis is a valuable diagnostic tool but not one of paramount importance. Properly employed, it gives much useful information. The new tubeless method of analysis will render this test more acceptable to patient and doctor alike.

ANNOUNCEMENTS

PROCTOLOGISTS' ANNUAL MEETING

The Eighth Annual Convention of the International Academy of Proctology will be held in the Drake Hotel, Chicago, April 23-26.

Subject matter will include ulcerative colitis, carcinoma of the rectum and colon, hemorrhoids, ano-rectal strictures, pilonidal cysts, surgical complications of ano-rectal surgery, polyps, amebiasis, diverticulitis, fluids and electrolytes in gastro-intestinal surgery, anesthesia and many other related subjects.

Dr. James W. Branch of Hope is councilor for Arkansas.

Further details may be had by writing Dr. Alfred J. Cantor, secretary, International Academy of Proctology, 147-41 Sanford Avenue, Flushing 55, N. Y.

NATIONAL CANCER CONFERENCE

The American Cancer Society and the National Cancer Institute of the Public Health Service will jointly sponsor the Third National Cancer Conference in Detroit, June 4, 5 and 6. More than a thousand research scientists and clinicians, including many from foreign countries, are expected to attend.

The opening session of the conference, in the Sheraton-Cadillac Hotel, will feature addresses by Dr. John R. Heller, Director of the National Cancer Institute, and Dr. Charles S. Cameron, Medical and Scientific Director of the American Cancer Society. Morning and afternoon sessions of the three-day meeting will begin with a general session at which a subject of broad interest will be presented by an outstanding speaker. The general sessions will then break into various symposia to discuss cancer of different body sites, such as lung, gastro-intestinal tract and breast.

The last National Cancer Conference was held in Cincinnati, Ohio, in 1952.

Copies of the conference program and advance registration cards may be obtained from the National Cancer Conferences Coordinator, American Cancer Society, 521 West 57th Street, New York 19, N. Y.

All physicians are invited to attend.

THINGS TO COME

AMERICAN ACADEMY OF GENERAL PRACTICE

Washington, D. C. — March 19-23, 1956

ARKANSAS STATE MEDICAL ASSISTANTS SOCIETY

Little Rock — April 14-15, 1956

ARKANSAS MEDICAL SOCIETY

Little Rock — April 23-25, 1956

AMERICAN MEDICAL ASSOCIATION

Chicago — June 11-15, 1956

A GUIDE TO RECOVERY

We have received a small booklet from the Arkansas Tuberculosis Sanatorium titled "A Guide to Recovery—to Whom it May Concern."

This attractive little manual apparently is given each patient on entering the Sanatorium and it outlines clearly and interestingly the daily living that must be done to any one who has pulmonary tuberculosis.

We are convinced that every physician should see this booklet and have it available for anyone who is being sent to the Sanatorium for treatment. T. H. Lipscomb is Superintendent of State Sanatorium, and can furnish these on request.

Arkansas

TRAVELING

And Clipping Bits Here and There

From an address delivered to doctors and medical students by Rudyard Kipling, at Middlesex Hospital, October, 1908. The address is entitled, "A Doctor's Work in 'A Book of Words'," by Rudyard Kipling, published by Doubleday, Doran & Company, Garden City, N. Y., 1928.

"It may not have escaped your observation that there are only two classes of mankind in the world—doctors and patients. Speaking then as a patient, I should say that the average patient

looks upon the doctor very much as the non-combatant looks upon the troops fighting in his behalf. The more trained men there are between his body and the enemy the better.

"Doctors are a permanently mobilized army which is always in action, always under fire against disease and death. Of course, it is a little unfortunate that Death, as the senior practitioner, is bound to win in the long run; but we non-combatants, we patients, console ourselves with the idea that it will be the doctor's business to make the best terms he can with man's last enemy; to see how his attacks can be longest delayed or diverted, and when he insists on driving the attack home, to see that he does it according to the rules of civilized warfare.

"Every sane human being is agreed that this long-drawn fight for time that we call life is one of the most important things in the world. It follows, therefore, that the doctor who controls and oversees this fight must be amongst the most important people on this earth."

The argument for efficiency in education can have no permanent validity if the efficiency sought be not moral as well as intellectual. The ages of strong and definite moral impulse have been the ages of achievement; and the moral impulses which have lifted highest have come from Christian peoples—the moving history of our own nation were proof enough of that. Moral efficiency is, in the last analysis, the fundamental argument for liberal culture. A merely literary education, got out of books and old literature, is a poor thing enough if the teacher stick at grammatical and syntactical drill; but if it be indeed an introduction into the thoughtful labors of men of all generations it may be made the prologue to the mind's emancipation: its emancipation from narrowness,—from narrowness of sympathy, of perception, of motive, of purpose, and of hope.—From Woodrow Wilson's Inaugural Address as president of Princeton University, October 25, 1902.

FROM 535 N. DEARBORN

All Aboard for AMA's Annual Meeting in Chicago!

Plans are rapidly taking shape for the AMA's 105th Meeting June 11-15 in Chicago. AMA has lined up nearly five full days of lectures, scientific and technical exhibits, color television and

motion picture presentations to give physicians a good "short course" in post-graduate medical education. Between 12,000 and 15,000 physicians are expected to attend the convention which will center its activities at Navy Pier, Northwestern University, and near north side hotels. Headquarters for the House of Delegates will be at the Palmer House.

Some 350 Technical Exhibits and more than 300 Scientific Exhibits will be on display all week for the benefit of physicians and guests. The exhibit hall will be open "for doctors only" probably on Wednesday and Thursday mornings.

A few outstanding scientific features already scheduled include: fracture and fresh pathology exhibits; physical examinations for physicians; exhibit-symposiums on traffic accidents and arthritis and rheumatism; special exhibits on cardiovascular diseases and pulmonary function tests.

Physicians should begin now to make plans to attend this worthwhile medical meeting. More details will be published in the Journal of the AMA.

AMEF Kicks Off '56 Fund Drive

The American Medical Education Foundation's 1956 fund-raising campaign was officially inaugurated January 22 at a special meeting of state representatives. Encouraged by reports from AMA President, Dr. Elmer Hess of Erie, Pa., Woman's Auxiliary President, Mrs. Mason Lawson of Little Rock, Ark., and other national medical leaders, AMEF chairmen pledged themselves to greater efforts in 1956. The Board of Directors recommended that states set individual goals, keeping in mind the national goal of two million dollars for our country's medical schools. Some states at the present time are considering treasury grants and dues increases as ways of supporting medical education.

AMA Plans New Health Exhibits

Scheduled for release this spring are two new AMA health exhibits depicting different aspects of the human body. Developed by the Bureau of Exhibits, both displays feature life size three dimension models of parts of the body.

The first, entitled "We See," will be released April 1. Charts and diagrams show construction of the normal eye in comparison to a camera, and various panels deal with nearsightedness, farsightedness, and color blindness. A special feature of this exhibit will give viewers an opportunity to check themselves on whether or not they have any eye deficiencies.

The second exhibit, "We Hear," stresses the mechanics of hearing, showing how sound enters the ear and is carried to the brain. Also featured are panels on motion sickness, quackery in the field and the mechanics of hearing aids. This exhibit will be available about May 1.

Now's the Time . . .

In line with the old adage about the early bird getting the worm, the AMA's Bureau of Exhibits offers this bit of advice: Begin NOW to make plans for exhibiting at state and county fairs, home shows and other local events during the summer months. It's not too early for medical societies to contact fair and exhibit leaders for choice space. Medical societies also should put in their bids for AMA exhibits as the Bureau already has several reservations lined up for specific summer and fall dates.

AMA Film Library Grows

Reporting the biggest year of its existence, the AMA's Committee on Medical Motion Pictures distributed more than 3,000 films last year to medical societies, medical schools, hospitals and other medical groups. Each year the Committee adds many new films to its growing library. Now-

est addition is a film entitled, "The Doctor Examines Your Heart," which will be of particular value to the physician speaking before high school health classes or service clubs. In the film are demonstrations of the methods used by the physician in examining the heart. The film also touches on such things as percussion to determine heart size, listening with a stethoscope to the heart beat, determination of blood pressure and pulse rate, fluoroscopic examination and the use of electrocardiograms. Running time for this black and white film is 11 minutes.

Obituary

HUGHES, ARRANDA A., 69, a former Pine Bluff resident, died in Houston, Texas, January 10. He was for many years a member of his County Medical Society and of the Arkansas Medical Society. A native of Monticello, he left Pine Bluff in 1939 and lived in Texas for several years, locating in Houston in 1950.

Survivors include his widow, three sons and a daughter. Burial was in Houston.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

REPRODUCED FOR ARKANSAS PHYSICIANS BY THE ARKANSAS TUBERCULOSIS ASSOCIATION

"A CHRISTMAS SEAL SERVICE"

A LOOK AT HOME CARE

By JULIA M. JONES, M.D.

Bulletin National Tuberculosis Association, September, 1955

The recent increase in home treatment of tuberculosis patients has been much discussed. Some patients have always been treated outside hospitals, either from preference or because of a shortage of beds. Now with more effective treatment methods it is reasonable to broaden home treatment criteria if quality of medical care can be maintained.

Whether or not the idea is good, home care is already widely practiced. What is needed now is a critical evaluation of unhospitalized patients and criteria for the selection of patients and for

providing suitable medical care. Experience with chemotherapy is still of short duration and there are many unanswered questions regarding its efficacy. In adapting chemotherapy to home treatment the limitations should be considered.

Streptomycin and isoniazid are highly effective when properly administered. Isoniazid can be given by mouth and parenteral injections of streptomycin can be made by visiting nurses or in clinics. Symptomatic response is prompt, and the volume and infectivity of pulmonary secretions are usually reduced. Present knowledge indicates

that, to be effective, treatment must be prolonged for a year or more and must be continuous, that streptomycin and isoniazid are best given in combination or with para-aminosalicylic acid, and that surgical treatment is often necessary.

These drugs are usually not dangerous, but rarely toxic manifestation may require a change in drug regimen. Toxicity usually develops early and complications can be avoided if new cases are hospitalized during the preliminary period. Drug therapy is more often limited by the onset of bacterial resistance to the drugs, which is encouraged when therapy is interrupted or drugs are not given in proper combination. Extra efforts must be made to insure continuance of therapy when patients are treated outside the hospital.

Adequate observation of patients receiving drug therapy requires frequent clinical and roentgenologic observation and detailed laboratory studies. Since drug therapy is usually dramatically effective in relieving symptoms and is apt to encourage false optimism, thorough education of the patient is important at the onset and throughout treatment. It is difficult to achieve the same degree of understanding during brief office and clinic visits that is possible in the hospital.

It must be recognized that there are advanced cases of tuberculosis which cannot be cured and the patient remains a respiratory cripple. Although hospitalization provides only custodial care for these patients, outside the hospital they are potentially dangerous to the community. The patient at home is not necessarily ambulatory, and if needed rest at home is impossible, the patient should remain in the hospital. Additional benefits of rest should not be compromised in order to treat the patient at home.

As treatment methods become simpler and more easily administered, it may be anticipated that the specialist will deal only with the more complicated clinical situations. Unfortunately, the past isolation of tuberculosis patients has also isolated clinical experience and knowledge. Medical students, residents and practicing physicians need more experience and instruction regarding tuberculosis.

In the past hospitalization has been urged not only for the patient's benefit but also to isolate him during the infectious period. Does drug therapy reduce the danger of contagion sufficiently to ignore this safeguard? Factual data are needed before this question can be answered. It seems wise, however, to combine drug therapy with precautionary measures. The patient at home and

his familial contacts should be carefully instructed as to hygienic precautions and kept under close observation.

Some enthusiasm for home care is based on the assumption that it is less expensive. For the self-supporting patient, home care may be less costly than prolonged hospitalization, but when treatment is at community expense this saving is less certain. The patient still requires medical and nursing care, must be housed and fed, and his family must be assisted. This cannot be assumed to be inexpensive until overall costs have been studied.

In the hospital the patient can be provided with medical and other necessary services. When patients are geographically dispersed, services become difficult to provide and the treatment team, including doctors, nurses, social workers, vocational counselors, public health nurses and recreation workers may be too dispersed to be efficient. Provision of such services for unhospitalized patients is a challenging problem. Relapse is now less frequent following effective treatment, but relapse potentialities still exist and may be decreased by careful rehabilitation.

Home treatment offers advantages for selected patients if all clinical and personal needs can be met. Family integrity can be maintained with the patient as a participating member. The successful "home treatment" patient must assume greater responsibility for his conduct and treatment, thus avoiding attitudes of dependency. The home should be physically adequate and family relationships must be sound.

Application of home treatment is limited for the numerous detached, homeless men who attend clinics from unsheltered living situations. Many of these patients adapt poorly to institutional life. In general the poorly adjusted individual is a poor patient inside or outside a hospital.

During the period of preliminary hospitalization for new tuberculosis cases long-range plans can be formulated after doctors, social workers, and vocational advisors have evaluated individual needs. When suitable clinical response has been made, the patient can return to a well-planned home situation. Ideally he will then continue under supervision of the same staff. Later surgical therapy may be necessary and this can be performed as part of a well-integrated, continuous program of treatment. If home treatment cannot be continued under the auspices of the hospital in which treatment began, detailed information and plans

should be transferred to the patient's private or clinic physicians and social workers.

Hospital services are needed for new cases, for the clinically ill, and for specialized services such as thoracic surgery. The asymptomatic patient on prolonged drug therapy and the convalescent patient under continuing clinic supervision can be

treated at home if suitable arrangements can be made.

Much is to be gained from sharing experience in a period of change. A pooling of information from various parts of the country where home treatment programs are in progress should contribute to our understanding of the questions which have been posed regarding home treatment of tuberculosis.

Personal and News Items

James W. Case opened offices in the Walnut Ridge Hospital last month.

J. H. Burge has been elected to the Board of Directors of the Bank of Lake Village.

John Wright has returned to his home town of Benton after graduating from the University of Arkansas Medical School and spending two years in hospital training.

Carl D. Douglas, biochemist at the Medical School, is the recipient of a grant from the National Vitamin Foundation for work on citrus fruit compounds.

Paul Schaefer, Fort Smith, Executive Secretary, addressed the Woman's Auxiliary to the Pulaski County Medical Society, on "Medical Legislation," at the January meeting.

The Journal's apologies to Elmer W. Sydnor, Memphis, who has opened offices in Crittenden Memorial Hospital for the practice of Thoracic Surgery. We missed the spelling on the first attempt.

Travis Lambert Wells, Little Rock, has opened his office for the practice of Internal Medicine, in the Donaghey Building.

V. O. Lesh, Fayetteville, attended a three-day Postgraduate course at Jefferson Medical College in Philadelphia, in February.

The professional organization for Executive Secretaries of Medical Societies was held in Chicago the first week in February. Paul C. Schaefer, Fort Smith, attended from the Arkansas Medical Society.

At a meeting of the Memphis Surgical Society on January 25th, members of the staff of the University of Arkansas Medical Center gave the following presentations:

"Experimental Pancreatitis"—Bernard Thompson, resident in Surgery at the University Hospital.

"Adrenalectomy in Diabetes Mellitus"—James Headstream, Associate Professor of Urology.

"Observations on the Treatment of Aortic and Iliofemoral Arterial Disease"—Masauki Hara, Professor of Surgery and Oncology.

"Acute Perforated Peptic Ulcer"—James H. Growdon, Professor of Surgery.

John P. McAlister, Camden, addressed the Rotary Club in Camden recently. He spoke on Korea and showed slides made in the Far East.

J. H. Scoggin has moved from England to Morilton and opened offices.

W. P. Kolb of Little Rock spoke to the Cross-St. Francis County Medical Society on January 4, 1956, on "Criminal Law." Dr. Kolb made the trip as a representative of the Pulaski County Medical Society Speakers Bureau. Another member of the Speakers Bureau, E. H. Crawfis of Little Rock, spoke to the Cross-St. Francis Society on February 1st on "Forensic Medicine" and "Aspects of Sterilization and Malpractice."

At a recent meeting of the Neurosurgical Society of America, held at Key Biscayne, Florida, Robert Watson, Little Rock, was elected Vice President of the society for the coming year.

Dale Alford, Little Rock, has been appointed a member of the Board of Trustees of All-Saints College, in Vicksburg, Miss.

Registered at the Chicago meeting of the American Academy of Orthopedic Surgery January 29th were: Coy C. Kaylor, Fayetteville; Tom M. Durham, Jr., Hot Springs; W. E. Knight and P. Kirkpatrick, Fort Smith; and from Little Rock, John Hundley, Ralph Rowan, Sam Thompson, J. D. Christian, J. W. Shuffield, and Kenneth G. Jones.

A. J. Harrison, a 50-year member from Springdale, was selected as "Pioneer Citizen for 1956," of his home town at a meeting sponsored by the Chamber of Commerce.

E. H. Crawfis, Superintendent of the State Hospital for Nervous Diseases, addressed the Cross-St. Francis County Medical Society in Forrest City for their February meeting.

E. D. McKnight, Brinkley, was elected president of the State Board of Health at its quarterly meeting in Little Rock on January 26th. He has been a member of the Board for 29 years and has previously served as its head.

F. C. Dozier, Marianna, was elected vice-president and John T. Herron, Little Rock State Health Offices, is its permanent secretary.

L. M. Godley and G. J. Womack have purchased the Manila Hospital and opened there March 1st.

PROCEEDINGS OF SOCIETIES

The Miller and Bowie County Medical Societies held their annual invitational dinner meeting on January 21st, and had as their guest speaker, Michael DeBakey, Professor of Surgery, Baylor University, Houston, Texas. Dr. DeBakey spoke on the recent advances in cardiovascular surgery. More than 25 out-of-town guests attended.

The Arkansas County Medical Society elected Robert T. Cook of Stuttgart to head up the organization during the coming year. S. A. Drennen, Stuttgart, was named secretary-treasurer, and R. H. Whitehead, Sr., DeWitt, delegate to the State meeting, with E. A. McCracken, Stuttgart, alternate.

At the regular annual meeting of the Nevada County Medical Society the following officers were elected for the new year: President, Charles A. Hesterly; Treasurer, L. R. Turney; Delegate to Arkansas Medical Society, O. G. Hirst; Alternate Delegate, Glenn Hairston.

The Ouachita County Medical Society met in regular dinner session Thursday night, February 2nd, in Camden. The following scientific program was rendered: "Office Urology," Hal R. Black, Jr., Little Rock; "Blue Cross-Blue Shield," Mr. Al Ercolano, Little Rock.

R. B. Robins, Secretary.

H. K. Carrington is president of the Columbia County Medical Society for 1956. Blake Crow was elected vice-president and Charles Weber, secretary, at the February meeting. All are from Magnolia.

Arkansas Radiological Society

The Arkansas Radiological Society held its regular quarterly meeting January 7, 1956, in Little Rock. Members present: Burton, Regnier, Calhoun, Anderson, Ward, Pool, Barnhard, W. E. Gray, Norton, Buice, Sims. Guests present: Dr. Dodson, Dr. Little, Dr. Harold Langston.

Dr. Burton reported that there had been no further action from the Arkansas Rehabilitation Commission concerning fees.

The secretary reviewed recent correspondence to the Society and made announcements of coming radiological meetings.

Dr. Barnhard reported that Dr. David Gould was expected to report as Chief of Radiology at the University of Arkansas on February 1st. Dr. Barnhard also invited again the members of our Society to bring proven interesting films and participate in the film-reading session at the University, 7:15 p. m. on the second Monday in each month.

Dr. Howard Barnhard was received as a new member of the Society.

The secretary mentioned a long report received from the American College of Radiology entitled "Exemption of Hospitals from Taxation." This discussion is available to any interested person. No Society action was taken.

The meeting was then adjourned and a very interesting film-reading discussion was moderated by Howard Barnhard.

Joe A. Norton, Secretary-Treas.

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Jefferson County Medical Society has enjoyed three special speakers at their meetings this year. They were Mrs. Beatrice Thomas, Public Relations Officer of the State Civil Defense; Mrs. John T. Gray, State President; and Mrs. William Ellis, Southeast Regional Vice President.

They also sponsored a Style Show and Tea at the Hotel Pines. The proceeds from this tea go into a charity fund at the Davis Hospital. This fund was started by the Auxiliary five years ago.

A Northwest Arkansas District meeting of the Woman's Auxiliary to the Arkansas Medical Society was called for Friday, October 14, 1955, by Mrs. K. A. Siler of Siloam Springs, Ark., fourth Vice President. The meeting was held at the Washington Hotel, Fayetteville, and was preceded by a coffee hour. Benton County Auxiliary served as hostesses for this occasion. We heard a splendid and inspiring talk by our State President, Mrs. John T. Gray, followed by a discussion in which members participated. Concluding the meeting, the Auxiliary members then attended the Women's Civic Club luncheon, and heard Winthrop Rockefeller speak on Community Enterprises and Development.

The Woman's Auxiliary to the Washington County Medical Society had their regular meeting and traditional Christmas party at the new home of Dr. and Mrs. LeMon Clark on December 9th.

The Woman's Auxiliary to the Boone County Medical Society has had several interesting programs. The film, "When You Choose Nursing," was shown at their nurse-recruitment program. Civil Defense and literature on Health facilities were two other programs.

The Auxiliary also had a combined meeting with the Boone County Medical Society at which time Dr. B. N. Saltzman of Mountain Home gave a paper on Rural Health Problems.

The Woman's Auxiliary to the Crittenden County Medical Society was happy to send a gift to A.M.E.F. in honor of Dr. J. T. Irby. As was his choice, the gift went to the University of Ten-

nessee Medical Units in Memphis. The Auxiliary had a meeting at the Crittenden Memorial Hospital with a program on Nurse Recruitment. The Hospital Auxiliary has just begun sponsoring a scholarship for student nurses this year. We've started three students. One student spoke to us on why she wanted to be a nurse.

The Auxiliaries and Societies of the Fifth Council District met at Dewey's Steak House, El Dorado, January 26th for dinner. The Auxiliaries adjourned to another room where we heard an informal talk by our State President, Mrs. John T. Gray. After a short discussion we enjoyed a social hour.

Mrs. Mason G. Lawson, Little Rock, President of the Woman's Auxiliary to the American Medical Association, was honored at a dinner meeting of the Chicago Auxiliary on February 7th. On February 8th, she was guest speaker at a luncheon meeting of the Medical Society Executives Conference at the Drake Hotel in Chicago.

On February 13th she was in Denver for the Mid-Year meeting of the Colorado Medical Society and Auxiliary. During her stay, she addressed the House of Delegates of the Medical Society and was a guest of the Auxiliary at a tea on February 16th.

At a luncheon with Senator Byrd and Ex-President Hoover in the Waldorf Astoria on February 26th, Mrs. Lawson represented the National Auxiliary as one of a small group of national presidents invited to discuss the Hoover Report. Mr. Hoover entertained the group at tea in his apartment following the luncheon.

LETTERS

Dear Doctor:

Are your medical assistants members of the Arkansas State Medical Assistants Society? If not, why not encourage them to join.

In case you are not familiar with this Society, we'd like for you to know that the organization is approved by the Arkansas Medical Society; its purpose is primarily educational, and doctors themselves play an active part in the governing board of the group. The Society was organized in November, 1954, and we are very proud to say that we now have six component societies organized throughout the State.

At present we are making plans for our second annual convention to be held on April 14th and 15th, 1956, at the Marion Hotel in Little Rock, Arkansas. Saturday afternoon, April 14th, registration will begin at 3:00 P.M. Highlights for the evening will be a social hour, dinner, and entertainment. Sunday, April 15th, will include the annual business sessions, speakers, dinner and social hour following adjournment. Miss Charleen Hardeman, President, from Little Rock, Arkansas, will preside at the business sessions.

Other officers of the State Society are:

Miss Eva Antonio, President- Elect
Hot Springs, Arkansas

Mrs. Mattie Mae Hardaway, Treasurer
Texarkana, Arkansas

Mrs. Vivian Harris, Recording Secretary
Monticello, Arkansas

Mrs. Elizabeth Marsh, Corresponding Secretary
Little Rock, Arkansas

Mrs. Katherine Beaty is Convention Chairman and Mrs. Elza Lee Dunn is Co-Chairman, both of Little Rock, Arkansas.

We will be very happy to welcome any and all medical assistants to the meeting and we can promise them a very pleasant and informative weekend. So if you have any assistants that are not already members of the Society, won't you please encourage them to attend the convention and then they can decide for themselves what a valuable organization this is for medical assistants.

We'll be looking forward to meeting lots of new members and if there is any further information you or your assistant would like to have, regarding the convention or the society in any way, please let us know.

Sincerely

(Mrs.) Frances Reibe
Publicity Chairman
Arkansas State Medical
Assistants Society

1413 North Mosby Street

El Dorado, Arkansas

Miss Nicholson has provided a handbook by which a community, church, or individual can be guided in their plans for long term hospital and convalescent facilities. She has collected a large mass of information and presented it clearly and succinctly and, best of all, completely.

The book considers the subjects of: Are such institutions needed; How can they be financed; Where are they best located; and many other details including construction, management and operation. Miss Nicholson has a valuable reference work and book which provides help in an area where there is little other help to be found. It is well indexed for quick reference and provides invaluable information for its specialized field. No other modern text or handbook can approach it for completeness.

Hypnotic Suggestion: Its Role in Psychoneurotic and Psychosomatic Disorders: S. J. Van Pelt, M.B., President of the British Society of Medical Hypnotists. Pp. 95. 1956. Philosophical Library, New York. \$2.75.

Some historical remarks are followed by a series of case histories in which hypnosis is used therapeutically. These are demonstrative and interesting. The author marks the all-too-common mistake of believing that "Psychosomatic Medicine" is a new slant in medicine. He might be encouraged to consult Hippocrates!

The text is clear, holds the interest and can be of value in the ordinary handling of patients.

Handbook of Toxicology, Vol. I. Acute Toxicities of Solids, Liquids and Gases to Laboratory Animals: William S. Spector, Editor. Prepared under the direction of the Committee on Handbook of Biological Data; Division of Biology and Agriculture; The National Academy of Sciences; The National Research Council. Pp. 408. Jan., 1956. \$7.00. W. B. Saunders Company, Philadelphia.

This handbook is composed, almost completely, of technical tables giving data on the toxicity of various drugs and making this data immediately and readily available. The amount of work crowded into the pages is enormous, and it will serve as a valuable reference in its field.

It is the first of a planned series of handbooks on biological data, of the Division of Biology and Agriculture of the National Academy of Sciences. Four other volumes are planned to be published in the next two years. This first book is applicable to the toxicities of solids, liquids and gases to laboratory animals, and is of rare value to medical research workers. While the average practitioner would find use for it infrequently, it does present a wealth of tables and statistical material for those needing such an occasional reference.

BOOK REVIEWS

Planning New Institutional Facilities for Long Term Care: Edna Nicholson, M.S., Executive Director of the Institute of Medicine of Chicago. 1956. Pp. 358. G. P. Putman's Sons, New York. \$4.50.

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The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

April, 1956

No. 11

CONSIDERATIONS IN THE MANAGEMENT OF INFECTIOUS HEPATITIS*

By JOE H. HARDIN and JEROME S. LEVY, Little Rock

Infectious hepatitis continues to be a cause of concern to all physicians whether they are general practitioners, internists, surgeons, or engage in other specialties. Many of us had greater experience with this disease during the war than in civilian practice. However, it is encountered frequently enough to present problems in management to all physicians. The purpose of this paper is to survey the clinical picture and its management. Infectious hepatitis is a viral disease which is transmitted by the oral route or by parenteral injection during the administration of medication, vaccines, blood, other intravenous fluids, etc. It may be acute, sub-acute, or chronic in its manifestations. It may be subicteric or there may be varying degrees of jaundice. The symptoms usually begin with a few days or two weeks of malaise, some loss of appetite, and possibly a day or two of loose stools. The latter, however, is not a necessary feature. There is often a slight elevation of temperature or the patient may just become aware of being jaundiced. It is recognized that fatigue and malnutrition may play a decided part in the development of an attack. This was noted particularly during the war.

In the mild cases, the physician is often presented with a greater problem in the management of the patient than in the management of the disease in the more serious states. We may stir up a rebellion against our advice in these patients because they feel so well and have so little apparent illness that they and their families cannot understand the necessity of a period of adequate rest and inactivity. In these cases, the chief complaint often is that the patient tires easily, feels unable to carry on a full day's work, has some loss of appetite, but otherwise feels fine. After dragging around for a few days, they seek medical advice. Their concern may be due to the darkening of the urine or because someone calls

attention to a barely perceptible jaundice. On physical examination there is little to be found except a mild icterus. Even this may be absent. There is apt to be tenderness on palpation of the liver which may be slightly enlarged. Concussion over the lower half of the right side of the chest may elicit pain in the right upper quadrant. There is a characteristic pause between the contact of the fist on the chest wall and the feeling of pain. This should arouse the suspicion of hepatitis. The only significant laboratory finding may be an increase in the urine urobilinogen. This can be tested for in the home or in the office by simple methods.* There may be a mild intolerance to fats or loss of appetite.

The more acutely ill patient will complain of having felt tired and worn out. There may have been a day or two of loose stools, though often this latter is not experienced. Fever may or may not be present. The patient becomes noticeably jaundiced. There is usually right upper quadrant pain, frequently aggravated by eating fats, and the urine becomes darker and the stool lighter in color. On examination, this patient is definitely jaundiced; temperature may range from 101° to 103° F; the liver is enlarged, and the edge round, smooth and tender. Concussion over the right lower costal arch produces fairly acute pain. Splenomegaly is found in about 30% of the cases. Cervical adenopathy is reported by many observers but we have not found this to be a prominent feature of the physical findings. The urine contains an increased amount of urobilinogen and bile is present.** Infectious hepatitis may strike with an even greater force of fulminat-

*It is easy to examine the urine for urobilinogen. It can be done in the home or in the office. The urine specimen should be examined soon after it has been voided. It must not be cold when examined. Ehrlich's Reagent can be carried in one's bag. 1.0 cc of the reagent is added to 10.0 cc of urine in a test tube. If urobilinogen is present, the urine will become red in color. A 1:20 dilution of urine can be made easily and the test repeated. A slight color in the 1:20 dilution is normal. A deeper color or any color produced in dilution greater than 1:20 is abnormal.

**A test tube containing urine is shaken. Bile is present if the foam is yellow.

ing character. The patient, then, is extremely ill with high temperature, marked toxicity, and rapidly deepening jaundice. The liver may be enlarged or hardly palpable, or even smaller than normal. There is definite tenderness of marked degree on palpation of the liver and on concussion over the lower right half of the thoracic cage. Obviously, the acutely ill patient must be treated in the hospital. It is best to have those even with mild attacks in the hospital for awhile. There is not any specific form of therapy. Fluids and electrolyte balance must be maintained but in the fulminating type caution must be exercised to avoid giving too much protein. Hepatic coma is more likely to develop in these patients if the protein intake is high. The ammonia formed during the protein metabolism is of major importance in the development of hepatic coma. The protein sparing effect of glucose in the body economy is well known. Adequate calories should be given. If the patient is vomiting, parenteral fluids are necessary to maintain in fluid balance, otherwise oral feedings of high caloric content and adequate water intake will suffice. Vitamin K by mouth or parenterally should be given to avoid a hypoprothrombinemia. Vitamin B complex is beneficial for its metabolic effects. Lipotropic agents, particularly choline and methionine are theoretically indicated for mobilization of fat from the liver, but it is highly questionable if they are of any value in the treatment of infectious hepatitis. On the contrary, they are useful in treating patients with fatty changes due to malnutrition and/or alcoholism, for these large daily doses may be given for five to seven days. Liver extract is of value because of its Vitamin B content but it is unnecessary if the patient is able to take vitamins orally.

Absolute bed rest is necessary and must be continued until the jaundice and tenderness have disappeared, the temperature remains normal, and the patient is eating well again. The laboratory tests must become normal or negative and remain so before the patient is allowed out of bed. It is at this period of treatment that patient resistance is apt to become more pronounced because he is getting stronger and thinks that his illness had now been cured. It is wise to remember and to emphasize to the patients and to their families that the clinical improvement precedes laboratory evidence, often by many days. The patient still should be considered sick until the cephalin-cholesterol flocculation and thymol turbidity tests become negative and normal respectively. It is important that the patient remain in bed until these do become negative or normal. If not, the infectious process which has not yet disappeared

will flare up and further illness of varying severity will follow. This danger cannot be emphasized too strongly because it is the most commonly encountered cause, in our experience, for the development of a chronic hepatitis. Many authorities question development of cirrhosis from chronic hepatitis or from an attack of acute infectious hepatitis, but we have seen several cases in which this sequence of events occurred. It is difficult for a physician to resist the pleas of the patient to get up and return to work because several weeks or more of illness have depleted his financial reserves. Too often we give in with sympathetic realization of the patient's problems, but we may have to face a recurrence of possibly even greater severity because the patient gets up to return to work too soon. When the clinical condition of the patient indicates the hepatitis has subsided and this is confirmed by the laboratory findings, the patient may be allowed to get out of bed. He is first permitted to sit up, then to exercise in increasing amounts each day. He is put back to bed if the liver begins to enlarge again, to become tender, or if there is an increase in the urobilinogen in the urine. These are danger signs indicating that there is activity remaining.

The greatest problems are encountered most often in the mildly ill patient who has only a feeling of malaise and fatigability. He may have been mildly jaundiced for only a day or a week and generally feels good. It is he who is difficult to keep in bed until he is well. As a rule he has been dragging around for several weeks before consulting his physician. He has taken some vitamins recommended by articles in popular magazines or on the radio, but is finally persuaded to see his doctor. The liver may be found to be tender. Urobilinogen may or may not be found in abnormal amounts in the urine. Cephalin-cholesterol tests will be positive, the thymol turbidity test increased, and there may be retention of bromsulphalein. This patient should be kept in bed until his appetite, and his strength have returned, and all clinical and laboratory evidences of disease have disappeared. Yet, too often, we have difficulty in getting this type of patient to go to the hospital or even to go to bed at home. No matter how mild the hepatitis, the patient should be in bed until recovery has taken place. Bed rest is the most important single feature of the treatment in our opinion. A diet containing a high protein and high carbohydrate content is of secondary importance, and, as above mentioned, in the seriously ill patient, the protein content should be reduced. Brewers Yeast tablets are a very satisfactory source of the Vitamin B Complex and are the least expensive. We give

our patients fifteen to thirty tablets a day, or three tablespoonsful of the powder which can be given on cereal or dusted over different foods.

Summary

In summary, it is to be emphasized that an early or mild hepatitis must be kept in mind in any patient who presents a picture of malaise, gastrointestinal symptoms, and anorexia. The subicteric and pre-icteric case often is a greater challenge to diagnose than the frankly jaundiced patient. We urge that infectious hepatitis not be taken lightly and that the main treatment is bed rest with adequate carbohydrate intake. Liberal

amounts of protein are advised except in the severely ill, especially if there is impending coma. Bed rest should be continued until there is no clinical or laboratory evidence of activity. This is true regardless of the severity of involvement. In this way a chronic hepatitis and, in some instances, the possible development of a cirrhosis can be avoided. Parenteral therapy is needed only when oral feedings and medication cannot be given. The mild cases can be treated at home, although at least a few days of hospitalization will prove to be of benefit, if only to aid in emphasizing to patients and their families the importance of strict adherence to the doctor's orders.

BULLOUS DERMATITIS HERPETIFORMIS*

By CALVIN J. DILLAHA, M.D.†

The average case of dermatitis herpetiformis runs a benign course without effecting the general health of the patient. In children and in adults past the age of fifty, however, it is sometimes characterized by an extensive bullous eruption. Since any generalized bullous or blistering disease of the skin that persists may end in disaster, it is important for the general practitioner to recognize and treat this form of dermatitis herpetiformis as rapidly and effectively as possible. Serum and tissue proteins may be swiftly depleted through formation of bullae and the resultant denuded skin, thereby duplicating the condition resulting from extensive burns. Early treatment is of vast importance in preventing this serious complication.

Bullous dermatitis herpetiformis may at times be confused with contact dermatitis resulting from plants, particularly poison ivy; drug eruptions; and other less serious dermatoses. The condition is not common, but it is also far from rare.

The disease in all its forms responds particularly well to a group of drugs containing the pyridine nucleus and to several others such as para-aminobenzoic acid, promacetin and diasone, the last two being used also in the treatment of Hansen's disease. Included in the pyridine group are sulfapyridine, nicotinic acid, roniacol, and pyribenzamine. These drugs represent a major advance in dermatologic chemotherapy and may be

life-saving in acute cases of bullous dermatitis herpetiformis.

The adrenal steroids and adrenocorticotropin are also effective and necessary in the treatment of some cases, but prolonged therapy with these drugs is difficult because of the large doses usually required. In the past arsenic was widely used in treating the disease, but its use is now avoided because of late sequela in the form of keratoses and carcinomas.

Although sulfapyridine is considered the most effective and preferred therapy, each case of dermatitis herpetiformis presents an individual problem and no one method of treatment is routinely effective. In older patients with bullous dermatitis herpetiformis it is frequently necessary to employ large doses of adrenal steroids to bring the disease under control, after which remission may usually be maintained with one of the other drugs. It is also necessary to emphasize that treatment with the correct drug must be carried on indefinitely to keep the disease in remission.

The following cases are presented as illustrations of the problems of the diagnosis and treatment of bullous dermatitis herpetiformis:

1. Mrs. C. L. T., a white female of 65 years, was admitted to the hospital suffering from a generalized bullous dermatoses that had begun as a maculo-papular eruption 3 months earlier. The patient had a history of mild hypertension and was taking digitalis because of an episode of congestive heart failure. The erythema multiforme-like eruption had responded well to prednisone

*Received for Publication January 30, 1956.

†From the Division of Dermatology, Department of Medicine, University of Arkansas School of Medicine, and the Department of Medicine, St. Vincent's Infirmary, Little Rock, Arkansas.

administered by her local physician, but the eruption had recurred as the dosage was lowered. On admission the presence of numerous large bullae on an inflammatory base, the absence of a Nikolsky sign, the lack of involvement of the mucous membranes, and the marked pruritis all strongly suggested bullous dermatitis herpetiformis. This diagnosis was confirmed by the typical histology of a bulla between the dermis and the epidermis, which contained many eosinophils.

Initial therapy included prednisone, 10 mg. t.i.d.; roniacol, pyribenzamine, tetracycline, local anti-pruritic medications, sulfapyridine, and potassium para-aminobenzoate. Successive treatment with these drugs only partially controlled the development of bullae. The total serum protein went as low as 3.9 gms. %, the hemoglobin went down to 10 gm. or 64%, and the eosinophile count ranged as high as 42%. The disease was gradually brought under control with massive doses of hydrocortisone, 40 mg. every 6 hours by mouth; cortisone intramuscularly, 25 mg. every 6 hours; and corticotropin gel, 40 units intramuscularly b.i.d.

The patient developed a secondary glycosuria which was controlled with 40 units of NPH insulin daily. The patient was gradually switched to prednisolone in large doses, 15 mg. t.i.d., with subsequent loss of the edema fluid. The disease now continues under control after 6 months with 30 mgs. of prednisolone and 1 gm. of diasone daily. The glycosuria has subsided and insulin has been discontinued.

2. Mrs. C. B., a 72-year-old white female, was hospitalized with a generalized blistering eruption of over a year's duration. It started as patchy, pruritic, blistering areas on the back and scalp, gradually spread, and had been severe in the weeks before admission. She had had mild diabetes for two years but had received no insulin for over a year.

On admission large bullae were present diffusely on the flexural surfaces of the arms and forearms. There was a dry, erythematous, edematous dermatitis of the hands and grouped patches of vesicles with inflammatory bases on the thighs, legs, umbilicus and surrounding the neck. The mucous membranes of the mouth were not involved, itching was intense, and the Nikolsky sign absent. The diagnosis of dermatitis herpetiformis was confirmed by the presence of the typical findings at biopsy.

Treatment was begun with sulfapyridine, 0.5 gms. b.i.d., and promacetin, 0.5 gms. b.i.d., with

good resolution of the eruption, but the patient developed a fever and suppression of the red cell count after three days. These drugs were discontinued, and the patient placed on roniacol, 25 mg. t.i.d., and pyribenzamine, 50 mg. t.i.d. Resolution of the eruption continued until the skin was completely clear. This remission has been maintained for six months. Significant laboratory data during hospitalization included total serum protein of 5.45 gms. %, eosinophilia as high as 29%, and hemoglobin as low as 6.25 gms.

The patient was placed on 15 units of Lente insulin daily which controlled a moderate glycosuria and blood sugar that ranged between 187 mg. % fasting to 374 mg. % two and one-half hours postprandial.

3. Mrs. B. C. C., a 59-year-old white female, was in good health until three weeks prior to admission when she developed a scattered, erythematous, patchy, and vesicular eruption, mildly pruritic, on the flexural surfaces of the arms. The condition did not respond to symptomatic treatment and gradually spread with the generalized development of large, numerous bullae. The examination revealed large clear bullae on an erythematous base, negative Nikolsky sign, diffusely spread over the flexural surfaces of the arms and forearms (figure No. 1) and in patches over the trunk and legs. The mucous membranes were clear. Diagnosis of D. H. was confirmed by a typical histologic picture.

The patient responded well for the first 72 hours to sulfapyridine, 4.0 gms. daily and then large crops of new bullae appeared. In spite of a previous history of peptic ulcer, the patient was started on prednisolone, 20 mg. every 6 hours. Promacetin, 0.5 gms. b.i.d., was added to the therapy but seemed to aggravate the condition. The patient continued with prednisolone; pyribenzamine, 100 mg. q.i.d.; roniacol, 50 mg. q.i.d.; corticotropin gel, 40 units b.i.d.; and diasone, 0.33 gms. daily, with a gradual clearing of the eruption. Eosinophilia was as high as 18%, and the hemoglobin as low as 60.7% or 9.4 gms. The prednisolone was gradually discontinued over a period of two months and remission maintained for the past three months with 1 gm. of diasone daily.

4. L. V., a 2-year-old white male, suffered from a generalized pruritic blistering eruption of approximately six months duration. At the time of the initial examination he also had a generalized urticaria secondary to therapy with a penicillin sulfonamide mixture given for tonsillitis. The urticaria cleared with administration of benadryl,

but the generalized bullous eruption in patches with crusting persisted. The Nikolsky sign was absent, and the mucous membranes were clear. Itching was intense. The diagnosis of dermatitis herpetiformis was confirmed by the typical histologic picture on biopsy. Initial treatment consisted of roniacol, 25 mg. p.c. This did not bring the disease under control and the parents of the child took it upon themselves to stop treatment.

Two weeks later the child returned, suffering from a continued spread of the bullous eruption with severe pruritis. He was hospitalized for two days with an excellent response to sulfapyridine, 2 gms. daily. It was continued in doses of 2 or 3 gms. daily, irregularly administered, for six months while the child was in California where his father was stationed in the service. No intolerance to the sulfonamide could be detected either by urinalysis or blood count. Sulfapyridine was discontinued and the child placed on elixir of roniacol (50 mg. t.i.d.). This resulted in good resolution of the disorder. The patient was subsequently lost from observation.

Comment

Each of these cases demonstrates some of the problems arising in the treatment of bullous der-



Fig. 1. Case No. 3, Dermatitis Herpetiformis. Bullous dermatitis of extremity resembling contact dermatitis.



Fig. 2. Case No. 3, Dermatitis Herpetiformis. Characteristic grouped patches of bullae.

matitis herpetiformis. Sulfapyridine, the drug of choice in the therapy of this disease, was not well tolerated in the elderly patients and resulted in suppression of the blood count and fever, even though helpful in controlling the disease.

Cases 3 and 4 were originally treated elsewhere as contact dermatitis, an easy mistake to make due to the close similarity between the clinical appearances of the two disorders. In case 3 there was an extensive bullous eruption of the extensor surfaces of the arms and forearms not unlike that seen in contact dermatitis (figure No. 1). However, as shown in figure No. 2, the patchy grouping of the bullae which was generalized rules out contact dermatitis. Erythema multiforme was closely simulated by case 1 before the development of bullae.

Experience in these cases emphasizes the need for massive therapy with the adrenal corticoids and corticotropin in severe cases. The disease may be well controlled in other instances by simple therapy such as roniacol and pyribenzamine. The marked protein depletion that may occur was demonstrated in one case. The maintenance therapy finally arrived at in each case, every one different, illustrates again the vast difference in disease activity in each individual.

Summary

Four cases of bullous dermatitis herpetiformis as seen in children and older adults are presented. The diagnosis was established in each case by the presence of the typical clinical and histopathologic picture. Each case presented a separate diagnostic and therapeutic problem, one of which is the similarity of bullous dermatitis herpetiformis to other common vesiculo-bullous dermatoses such as contact dermatitis.

RECENT ADVANCES IN THE BASIC SCIENCES*

ORVILLE T. BAILEY, Indianapolis, Ind.†

In undertaking a review of recent advances in the basic sciences as they relate to the clinical practice of medicine, the greatest problem is that of selection. It might be useful to begin by attempting to state in a few words the difference between clinical research and basic science research. Clinical research deals with problems directly concerned with the mechanics and treatment of human disease and is usually carried out on patients suffering from the disease under investigation. Basic science research is concerned with the increase of our knowledge of living tissues. Whether these results will have direct application to human disease is not the immediate concern of the research worker in the basic sciences. However, new facts in the basic sciences frequently open new leads for clinical investigation.

It is a curious fact that there is a considerable time-lag in incorporating new results and new methods in the basic sciences into the fabric of clinical medicine. In the fields of physics and chemistry, this has been estimated to vary from ten to twenty years. With this in mind, I shall begin my review with some account of research dealing with the internal structure of cells, even though direct applications to clinical medicine are not yet apparent.

The last ten years have seen the publication of research which has led us toward some understanding of what takes place within individual cells as units. It has long been possible to observe cells by means of the microscope, either in a fixed state or in living tissues, at least in favorable locations. An example of this approach would be the classic studies of Speidel¹ on the formation, maintenance and repair of peripheral nerves as observed in the living tadpole's tail.

This is one level of understanding the cell. It is quite different to see what chemical interchanges go on within it and how these processes result in the activities which we call "living." One of the greatest steps forward in this direction was that made by Lipmann² when he discovered coenzyme A. This coenzyme, occurring in all cells, acts on the acetyl groups so as to provide concentrations into larger molecules, which is a fundamental mechanism for uniting carbon-containing groups together into long carbon chains. To quote Lipmann's own comment,³ "The carriers of activated

chemical fragments are the condensing agents, gluing together small building blocks to construct the chemical structures that are the medium of living organization . . . the reason for the important function of carboxyl activation in biosynthesis is quite obvious from the composition of the major cell constituents. We find carboxyl links in most of them—in fat, in phospho-lipids, in protein, and in many polysaccharides."

The studies on the mechanisms by which cells build up their protoplasm, of which Lipmann's is an outstanding example, are in contrast to those of the older analytical chemists who had to break down the cells and could only describe what is there, not how it is built up. These, and related, investigations, point the way to better understanding of all metabolic diseases—a long goal, but a worthy one. These diseases often are the result of a biochemical lesion in contrast with those which produce tissue changes visible under the microscope. Only as a result of such studies can we follow the precise mechanisms involved.

Another method of approaching the nature of intracellular organization is by the use of X-ray diffraction. As long ago as 1912, it had been shown that when inorganic crystals were exposed to X-rays, the X-rays would be diffracted in accordance with the pattern of that particular crystal, just as light rays are by a prism. Though it was suggested that such technics could be applied to living tissues as much as twenty-five years ago, the method has been fully used only in recent years. As Baitzell⁴ has summarized the results obtained by this method, "Protoplasm itself, as found in various types of highly differentiated cells such as those of muscle and nerve, has a basic structural pattern extending from molecular levels to a visible crystalline pattern in the cell units. . . . It is definitely established that the genes in a chromosome are arranged in a precise pattern. . . . Each chromosome may be regarded on this basis as a huge protein molecule, or crystal, in which the genes and the accompanying substances are built into a specific crystalline pattern characteristic of the species." It looks as though we are at last getting somewhere with the mechanism of heredity and of hereditary diseases.

The method of X-ray diffraction has also been useful in showing that viruses are really huge molecular crystals. They come as near as anything we know to being intermediate between the living and the non-living.

*Presented at the Annual Meeting of the Arkansas State Medical Society, May 31, 1955.

†From the Department of Neurology (Neuropathological Laboratory), Indiana University Medical School, Indianapolis, Indiana.

The mention of viruses brings us to an account of the much publicized work of Enders and his associates, especially Robbins and Weller⁵—publicized because of a direct application to one clinical problem rather than because of its broader implications. Here again, certain problems have been solved and a host more opened up by a new method. Up to the time of Enders and his co-workers, viruses in tissue cultures could be maintained only after they had been established by other means. Tissue cultures had usually failed to uncover new viral agents, especially from human sources. Enders found, however, that cultures of human cells, especially embryonic cells, were very well suited for the isolation of viruses, including those responsible for human diseases. Already the method has added to our knowledge of poliomyelitis and other infections of viral origin. Using this method, the propagation of viruses of herpes zoster and chickenpox has been accomplished. A variety of viruses producing human disease with symptoms of non-paralytic poliomyelitis and transverse myelitis have been isolated by a similar technic. It does not seem unduly hopeful to predict that this is only a beginning and that eventually many diseases now postulated as of viral origin without proof will be proved so or will be known to have another etiology. The value of the method for the study of viruses has nothing to do with the outcome of the present anti-poliomyelitis vaccine, which makes use of it for mass production of poliomyelitis virus.

There is another phase of tissue culture which should be mentioned. This is the long-term program of Pomerat⁶ on the cultivation and movie photography of cells of the brain. Starting from results obtained by Russell and Bland⁷ in 1933, he has shown that many brain cells, especially the oligodendroglia, are in a state of undulating motion. Additional information has been obtained concerning many types of cells in the central nervous system. Of special interest is the fact that nerve cells can be grown in numbers from the brain of fetal or newborn animals. These can be subjected to the direct action of toxic agents and the effects observed. It would seem, however, that the utmost caution should be used in interpreting the results on individual cells as indicating the mode of action of these agents in human patients. The nerve cell tissue cultures represent only one element of a complex organism in which myriads of elements interact.

The applications of radioactive isotopes in biology and medicine have been thoroughly discussed in connection with problems varying all the way from those dealing with the physiology of the

isolated cell to total warfare. Artificial radioactive isotopes can now be produced in great variety. Each radioactive isotope has a different atomic weight from its stable counterpart but is chemically identical with it. There is no difference in chemical reactions or physiological processes between, for instance, a stable or a radioactive sodium atom. However, the radioactive form disintegrates and emits radiation in the process. It is by this radiation that we can follow the atoms wherever they go. By incorporating an appropriate one in a compound of which we wish to study the fate, we can see whether it is excreted, metabolized into some other chemical substance, or stored.

The applications of this method are so numerous that it is hardly possible in a brief review to mention even the general areas of research in which it has given valuable results. Only as examples, I cite the fields of intermediate carbohydrate metabolism, lipid metabolism, protein synthesis and hematology.

One of the most immediately useful applications in clinical medicine is that of I^{131} as a test for thyroid function and as a means of treating thyroid carcinomas. Recently, this same isotope has been used for a "chemical total thyroidectomy" in patients with cardiac diseases.⁸

It will take some time before all of these uses of radioactive isotopes can be fully evaluated in the clinic, and some of the methods evolved for their use have proved disappointing. This includes the use of P^{32} for the localization of intracranial tumors. Most methods for the determination of radioactive isotopes involve an experimental error larger than is generally recognized, and in many cases long-term evaluation of a method using these substances must be made.

At the present time, hardly a month goes by without the report of a new use for radioactive isotopes in biology and medicine. This is matched by an equally feverish activity in basic research on the physics and chemistry of the atom. But what of the destructive effects of the radiation, upon which the attention of the world was focussed on August 6, 1945? These destructive potentialities, terrifying in their implications in mass warfare, have been harnessed to destroy tissue for therapeutic ends, as in the case of I^{131} . In the case of tumors without specific chemical affinity, there is an interest in implantation of radioactive materials directly into the neoplasm. Normal tissues beyond the lesion are also damaged, a factor now under active study in many laboratories. Gamma radiation, which is similar

to X-ray, affects normal tissues in about the same order of sensitivity as X-ray, though perhaps a little more intensely, dose for dose.

One phase of this reaction which has interested me particularly is that gamma radiation, like X-ray, produces an effect on tissues which increases with time and becomes more and more evident histologically. This means that there is a continuing injury, even though no more irradiation is given. This is not wholly secondary to scar formation. It is as though an initially pure biochemical lesion gradually becomes histologically manifest."

Scientific advances are made possible or are gradually accelerated by the discovery of new technics to attack problems previously unsolved because there was no way to approach them. Yet it is equally true that the new ways of thinking stimulated by these discoveries may in the long run advance knowledge more. Pure speculation may be correct or incorrect; speculation, reined by experiment, is the key to the new. So long as we elaborate what is already known and so long as we are timid about testing a hypothesis because it seems bizarre, we merely move; we do not progress.

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RESOLUTION

Presented to the Pulaski County Medical Society
March 6, 1956

WHEREAS, an all wise Providence has seen fit to remove from our midst, Dr. J. B. Crawford, he was our valued co-worker and a faithful member of the Pulaski County Medical Society, the Arkansas Medical Society, and the American Medical Association since 1938: We, the members of the Pulaski County Medical Society, mourn and deeply regret his sudden departure;

WHEREAS, as a Physician in his chosen field of ophthalmology and otolaryngology, he attained a great measure of distinction and won the respect and admiration of his colleagues, as well as the gratitude and love of a host of sorrowing people.

THEREFORE, be it resolved that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of this Society and its heartfelt sympathy to the family at the untimely loss which it has sustained;

BE IT FURTHER RESOLVED that a copy of this resolution be made a matter of record in the minutes of the Pulaski County Medical Society; that a copy be sent to the family, and a copy to the **Journal** of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

Robert Caldwell,
C. J. Watkins,
John G. Watkins,
M. J. Kilbury, Sr.

Read and adopted March 6, 1956.

BUY
U. S. SAVINGS
BONDS

— ★ Editorial ★ —

At the direction of the Council of the Arkansas Medical Society an Editorial Board of the **Journal** has been appointed. This Board will serve as advisor to the Editor, and it is possible that an assistant editor may be selected.

The selection of this Board has been chiefly from those members of the Society who have taken an active interest in the **Journal**, and who have contributed to it. Some are on editorial boards of other medical publications, and, without exception, each appointee has contributed to the medical literature in the past few years. It is presumed that these members will serve for the coming year of the Society, beginning in April, unless the Council sees fit to stagger the terms, and make the Board a more permanent one, as is done with the other committees of the Society.

The members appointed to the Board are:

Alfred Kahn, Jr., Little Rock; W. R. Brooksher, Fort Smith; Euclid M. Smith, Hot Springs; R. B. Robins, Camden; C. Lewis Hyatt, Monticello; James T. Wortham, U. of A. Medical School; H. W. Thomas, Dermott; C. R. Ellis, Malvern; Roy Millard, Russellville.

This Board will convene from time to time, and will be expected to contribute of their time, and of their wisdom to the improvement and editorship of the **Journal**.

Goals have been set for funds needed by medical schools everywhere and a nation-wide "Medical Education Week" has been designated for April 22-27, the week of the Annual Session. Physicians are asked to give some two and a quarter million dollars from their pockets to the support of the country's medical schools. Eight million more is expected from the big industries and other Philanthropists. The many huge Foundations will supply more funds than these as they do annually, to certain schools but Education Week is set to call attention to the average giver, and to see that all medical schools share in our philanthropies.

For our slogan, we borrow a phrase from W. R. Brooksher's report to the Arkansas Medical Society on the subject: **"Give generously, give annually."**

Your gift will help prevent the government from taking over and dictating to our Medical schools.

GUEST EDITORIAL

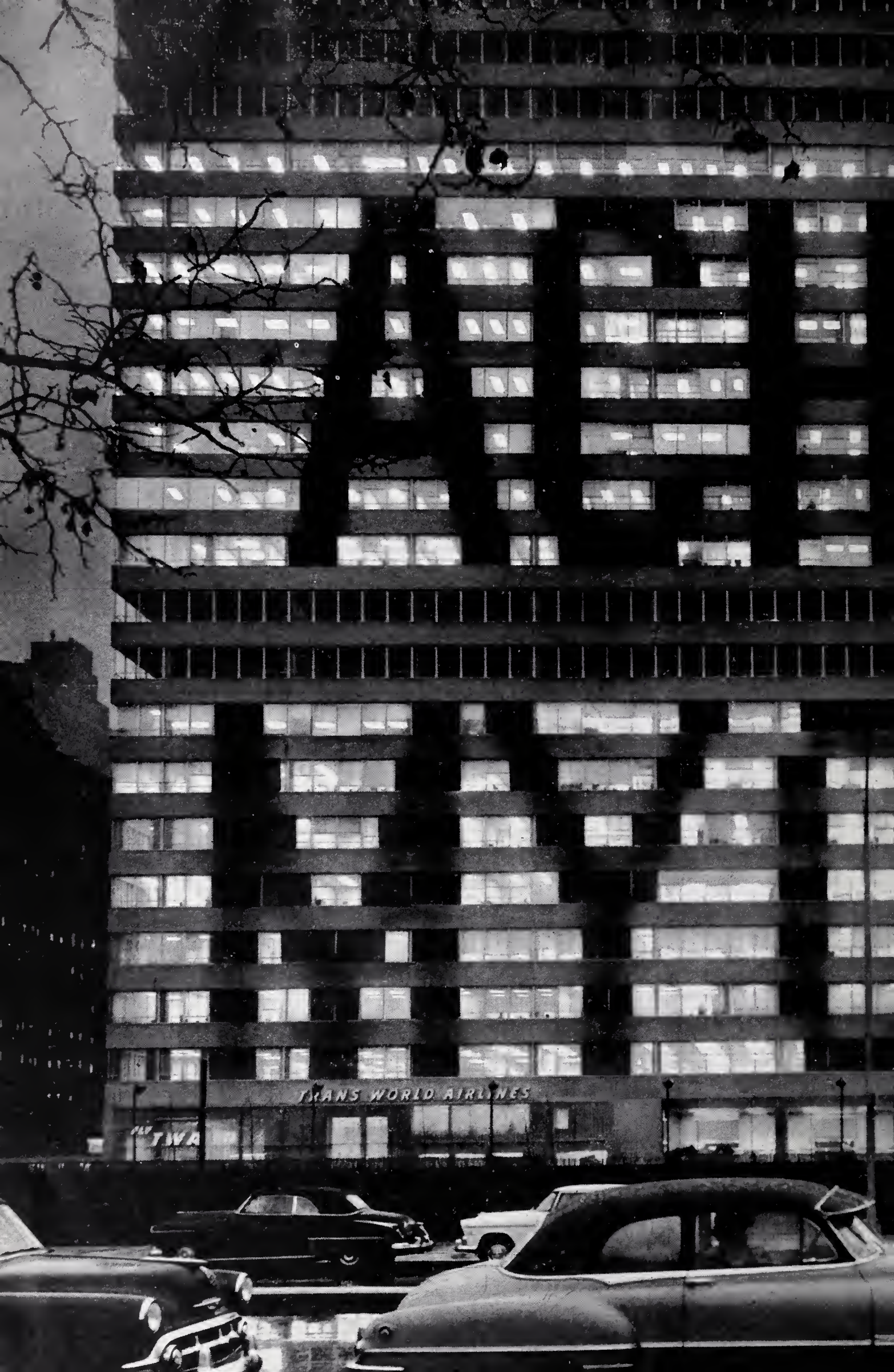
ENDOCRINOPATHY ASSOCIATED WITH MALIGNANT CARCINOID

ALFRED KAHN, JR., Little Rock

From time to time interesting new facets of a well-recognized disease will be uncovered. Such is the case with carcinoid. This growth has the microscopic appearance of malignancy but usually is benign in its biological behaviour. Boyd and others have drawn attention years ago to the resemblance of the cells of carcinoid tumors to the cells of chromaffinoma tumors—also called argentaffinoma (Wm. Boyd, *Textbook of Pathology*, 2nd Edition, 1934). In view of the known relationship of argentaffin cells to endocrine activity, it is rather surprising that the first comprehensive paper on a new syndrome involving this tumor was not published until 1954 when Thorson, et al. (*American Heart Journal* 47, 795, 1954) published a paper entitled: "Malignant Carcinoid of the Small Intestine With Metastases to the Liver, Valvular Disease of the Right Side of the Heart, Peripheral Vasomotor Symptoms, Bronchoconstriction, and An Unusual Type of Cyanosis: A Clinical and Pathologic Syndrome."

Since then other papers have appeared on this subject (Snow, et al., in *Lancet*, CCLXIX, 1004, November 12, 1955; Bean, et al., in *Circulation* 12, 1, July, 1955; etc.). An interesting recent report on this subject by Daugherty, et al. (*Proceedings Staff Meetings of the Mayo Clinic*, 30, 595, December 14, 1956) describes a malignant carcinoid which when manipulated produced a typical attack. The earliest attacks of this patient were characterized by palpitations, diarrhoea, and stiffness of face. Later attacks produced tenseness, weakness, nausea, flushing, tingling of extremities, epigastric pain and dysphagia. Chemical studies indicated the vasoactive substance was serotonin. Serotonin was released from the carcinoid tumor not alone by manipulation but apparently also by intravenous histamine given in the same manner as to patients suspected of having a pheochromocytoma; in the latter tumor not serotonin but adrenalin and noradrenalin are released to produce paroxysmal hypertension.

The successful investigations of the obscure relationships of certain tumors to endocrinopathies is a fascinating medical chapter, that is far from fully explored. For example, six cases of non-pancreatic tumors associated with severe hypoglycemia have been reported. (Silvis and Simon, *New England Journal of Medicine*, Vol. 254, Page 14, January 5, 1956.) The research into these unusual cases may lead to knowledge of practical value in the everyday practice of medicine.





ACHROMYCIN^{*}

Tetracycline Lederle

in the treatment of

respiratory infections


January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

 For more rapid and complete absorption. Offered only by Lederle!

¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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THINGS TO COME

ARKANSAS STATE MEDICAL ASSISTANTS SOCIETY

Little Rock — April 14-15, 1956

ARKANSAS MEDICAL SOCIETY

Little Rock — April 23-25, 1956

AMERICAN MEDICAL ASSOCIATION

Chicago — June 11-15, 1956

ANNOUNCEMENTS

ARKANSAS CHAPTER AMERICAN COLLEGE OF CHEST PHYSICIANS

April 22, 1956

Marion Hotel, Little Rock

6:00 P.M.—Fellowship Hour—Dinner

8:00 P.M.—Scientific Session:

Roentgen Findings in Lupus Erythematosus—David M. Gould, Professor and Head, Department of Radiology, University of Arkansas Medical Center, Little Rock, Arkansas.

All physicians are cordially invited to attend. There is no registration fee.

William Paul Gray,
Batesville, Secretary.

Editor: Journal of the Arkansas Medical Society:
Sir:

Dr. Grant Taylor, Dean of the University of Texas Postgraduate School of Medicine, has designated the Texarkana area as one of the sites for a series of postgraduate assemblies to be held during the year 1956. There will be three assemblies, the first one being held March 18, the second July 15, and the third October 14.

These postgraduate assemblies will be designed for the general practitioner, and six hours credit will be allowed for each assembly for the Fellows of the American Academy of General Practice. The University of Texas has funds set up to pay the expenses of this postgraduate instruction, although there will be a tuition fee of \$10 payable to the University of Texas for each attending doctor.

Since Texarkana is a border city and the state of Arkansas is represented as well as the state of Texas, Dr. Taylor has emphasized that the Arkansas physicians will be encouraged to take advan-

tage of this postgraduate instruction as well as the Texas physicians. I am enclosing the program for the first postgraduate assembly and will appreciate it very much if you will place some type of announcement in the next issue of the **Journal**. Also, it might be possible for the Arkansas Chapter of the American Academy of General Practice to get this information to the Fellows in this area.

Wm. B. Harrell, Chairman,
Postgraduate Committee,
St. Michael's Hospital, Texarkana.

AERO MEDICAL ASSOCIATION

The Annual Meeting of the Aero Medical Association will be held at the Drake Hotel, Chicago, Illinois, on April 16, 17, and 18. This year's meeting will provide the most comprehensive review of current progress in Aviation Medicine ever presented. There will be 137 papers presented dealing with every aspect of the field and coming from military and civilian sources in nine countries. Of particular interest will be the section meetings which will include in their agenda panel discussions of vital topics by top authorities in each field.

SURGEONS TO HOLD SOUTHEASTERN REGIONAL MEETING

The United States Section of the International College of Surgeons will hold a Southeastern regional meeting in the Read House, Chattanooga, April 30 and May 1.

The program will include the presentation of 17 scientific papers, three panels, dinner and luncheon with speakers, and exhibits.

Dr. William G. Stephenson of Chattanooga, United States Section regent for Tennessee and general chairman of the meeting, will preside.

AT SARANAC LAKE

The Fifth Annual Symposium for General Practitioners on Tuberculosis and other Chronic Pulmonary Disease will be held in Saranac Lake, New York, from July 9th to 13th, 1956.

This five-day course is designed particularly for General Practitioners and presented over a period short enough so that they may readily attend. Many of the sessions are informal panel discussions with ample opportunity for questions from the audience.

The registration fee for the Symposium is \$40.00. Further information and copies of the program can be obtained by writing Dr. Edward N. Packard, General Chairman, Symposium for General Practitioners, P. O. Box 262, Saranac Lake, N. Y.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled Examinations (Part II) oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 11 through May 20, 1956. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examinations will be notified of their eligibility for the Part II examinations as soon as possible.

Applications for certification (American Board of Obstetrics and Gynecology) for the 1957 Part I Examinations are now being accepted. Candidates are urged to make such application at the earliest possible date. Deadline date for receipt of applications is October 1, 1956.

All candidates for admission to the Examinations are required to submit with their application, a plain typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application or the year prior to their request for reopening of their application.

Application for re-examination, as well as requests for resubmission of case abstracts, must be made to the Secretary prior to October 1, 1956.

Robert L. Faulkner, M.D.,
American Board of Obstetrics
and Gynecology,
2105 Adelbert Road,
Cleveland 6, Ohio.

Arkansas

TRAVELING

And Clipping Bits Here and There

The government in business may waste time and money without rendering service. In the end the public pays in taxes. The corporation cannot waste or it will fail. It cannot make unfair rulings or give high-handed, expensive service for there are not enough people willing to accept inferior service to make a volume of business that will pay dividends.—Henry Ford.

"The government has been clever in trying to involve the professions to such an extent that they cannot very well retreat. However, the scheme is transparent; here it is: the government says to the medical profession: 'Come, take federal funds for socialized medical education, socialized research, socialized hospitals, socialized insurance, socialized annuities, socialized survivor benefits.'

"Some members of the medical profession have swallowed the bait without realizing they would place themselves in a ridiculous position if they were to accept all these forms of socialism and then refuse to take the last step, namely, the socialization or nationalization of medicine.

"If physicians are going to accept all the socialistic bribes, they cannot logically refuse to make their contribution to the socialist state, namely, the provision of medical care under Federal auspices. It would be absurd to say to the Federal government: 'Give me funds for medical schools, hospitals, research centers. Give my widow and orphaned children lush survivor benefits if I die while I'm young. Give me a "cheap" annuity when I'm old and retired, but don't ask me to furnish socialized medicine during my prime. I am opposed to socialism.'

"The segment of the medical profession that is yowling for voluntary inclusion in Social Security would show better judgment by far in vigorously supporting the Jenkins-Keogh bills, which would grant them the same right now enjoyed by labor of setting aside a certain amount tax free to make provision for their own security.

"Those doctors who think that this is an incomparable insurance opportunity aside from the unsoundness of the plan should consult their insurance agent about the cost of diminishing term insurance which for most doctors would be a better deal.

"Benefits originally designed for manual, factory, and office workers are not suitable for professional persons. Surely the self-employed are not so blind as to 'fall for' a few lush benefits given away by the government in order to promote one more taxing scheme.

"Social Security is NOT a contract to provide specific benefits. Benefits may be given or denied, increased or DECREASED at the will of Congress (Section 1104, Social Security Act).

"Doctors—socialized security is as wrong as socialized medicine." — Quoted from Charles W. Pavey in the Bulletin of the Southern Ohio Society of General Practice.

FROM 535 N. DEARBORN

A.M.A. ISSUES BOOKLETS ON JOB ABSENCE

Keeping Joe Worker healthy and on the job is a major problem facing both physicians and industrial leaders. Two new publications dealing with the problem of work absence have been prepared by the AMA's Committee on Medical Care for Industrial Workers — a joint committee of the Councils on Medical Service and Industrial Health. The first—a reprint from the January, 1956, issue

of AMA **Archives of Industrial Health**—was prepared for the Committee by Mark S. Blumberg, M.D. and James A. Coffin of the USPHS's Occupational Health Program. Entitled "A Syllabus on Work Absence," this booklet contains basic information for evaluating much of the data already published in this field.

The second pamphlet, "Company Medical Programs and Work Absence — 10-Case Studies," discusses the medical programs of 10 companies and how they deal with non-occupational job absence. In addition to a brief description and history of each program, the booklet includes information on medical facilities and personnel, diagnostic aids and in-plant services, the problem of absenteeism, costs and benefits of medical department functions, and relationships existing between the medical department and the private practitioner.

Single copies of these publications are available free of charge from the AMA.

RE: HIGH SCHOOL SCIENCE FAIRS (From Leo E. Brown at A.M.A. Headquarters)

Encouragement of high school students with scientific talent, through science fairs, falls in the areas of both community service and very effective public relations. Here, for example, is a quote from a faculty member of the University of Indiana's Department of Biology, which indicates how well the public thinks of your participation: "Two of the local county societies have already indicated an interest in co-sponsoring the Northwestern Indiana Regional Science Fair with the University. I have hopes that with this additional encouragement the others will want to join this activity. Personally, I feel that the stimulation they can give to Science Fair activity on the local level is as important as any financial assistance they might render."

. . . Medical societies have already entered the program. Their interest is particularly gratifying because, as recent as just last year, only three of the 71 state or regional science fairs in the United States were sponsored by medical societies.

As you know, the A.M.A. will present two citations to the students with the best exhibits on medical research, general health, or physical fitness at the National Science Fair next May 10-12 in Oklahoma City. Dr. Alphonse McMahon, chairman of the A.M.A.'s Council on Scientific Assembly, will head the committee of five physicians making the selections. In addition, the two winners will be invited to display their exhibits in the scientific exhibit at the A.M.A.'s Annual Meeting in Chicago, June 11-15.

If your society is interested in enlarging its vocational counselling activities by sponsoring a local fair, may I suggest you write to Science Clubs of America, 1719 N Street, N.W., Washington 6, D. C. This organization will send you complete details on the formation and operation of a local fair.

Tennessee State Medical Association's Woman's Auxiliary has asked its county memberships to participate in all local and regional science fairs.

Texas Medical Association's Woman's Auxiliary has formed a "Special Committee on Science Fairs" to prepare for state-wide participation in all science fairs. The Auxiliary hopes to sponsor a health fair and a science fair, simultaneously, following the 1957 state medical convention in Dallas.

Our congratulations to a sister medical society on the anniversary of its founding. The Arkansas Medical Society commends the Medical Society of the County of New York on the occasion of its 150th anniversary celebration.

New York County, the Island of Manhattan, not only has the largest of all local medical societies but it carries on the traditions of medicine in the busiest and most critical spot in the nation in terms of medicine.

Obituary

DR. JAMES BRECKENRIDGE CRAWFORD, aged 70, a retired surgeon and physician, died February 22, 1956, at his home.

Dr. Crawford was a member of the staff of St. Vincent's Infirmary and Arkansas Baptist Hospital. He was an eye, ear, nose and throat specialist. He was a member of the Second Presbyterian Church, Arkansas Consistory I, Scimitar Shrine, Pulaski County and Arkansas Medical Societies and American Medical Association and was a consultant staff member of the Missouri Pacific and Arkansas State Hospitals.

Dr. Crawford was a graduate of the University of Arkansas School of Medicine. He did post-graduate work in eye, ear, nose and throat at Tulane University at New Orleans in 1922. Dr. Crawford did general practice at Benton until he moved to Little Rock in 1923. He retired in 1955.

Survivors include his wife, Mrs. Hattie May Cleveland Crawford; a son, two daughters; a brother, Dr. S. R. Crawford of Little Rock; two sisters, and three grandchildren.

The funeral was held February 23 and burial was in Pine Crest Memorial Park, Little Rock.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

REPRODUCED FOR ARKANSAS PHYSICIANS BY THE ARKANSAS TUBERCULOSIS ASSOCIATION

"A CHRISTMAS SEAL SERVICE"

THE TUBERCULIN TEST

By FLOYD M. FELDMANN, M.D.

Medical Director, National Tuberculosis Association

NTA Bulletin, October, 1955

The time has come for a closer look at the tuberculin test as an aid to tuberculosis control and eventual eradication. What can it do and what are its limitations? Should every community have a testing program? Unfortunately, simple answers to such questions cannot be provided from the information now available. Those who attempt the best use of this tool must study their own problems in the light of the known facts and must follow this with studies of the results obtained by practical experience. This may sound formidable but will not be too difficult if consideration is given to some guiding principles.

The tuberculin test properly done is one of the most specific and reliable tests known to medicine. With few exceptions, persons who harbor live tubercle bacilli in their bodies will have an easily demonstrable skin sensitivity to the unique proteins produced by these organisms.

This fact makes it possible to identify actual or potential victims of the disease. The test does not reveal the location of the infection in the body, its extent, its activity, or when it might become a threat to health.

Nevertheless, the tuberculin test is widely used for three major purposes. First of all, it is used for diagnosis. When a person has suggestive findings, a negative test is good evidence that tuberculosis is not responsible for the illness. If the test is still negative when repeated after 30 days, tuberculosis can be ruled out. A positive test is not so conclusive because many people harbor tubercle bacilli in their bodies without symptoms and without significant harm to their health. However, a positive test is of great value in arriving at a diagnosis if it is known to have become positive recently, and even single positive tests are significant in young children and in population groups where infection rates are low.

Secondly, the test is used for information on the status of tuberculosis control efforts. Over a period of years, the tuberculin test will provide reliable measures of new infections taking place and therefore indirectly, of the number of active open cases of tuberculosis not under treatment. The epidemiological information obtained is useful in determining which population groups need attention.

Thirdly, the test is used to screen out those individuals who have been infected. This use of the tuberculin test as a first step in finding hidden cases of the disease is at once simple and complicated. Its efficient utilization depends on many factors.

For screening purposes in case finding the intradermal test (Mantoux) is preferred. For technical details see the 1955 edition of "Diagnostic Standards and Classification of Tuberculosis," published by the National Tuberculosis Association.

Under some circumstances "patch" tests may be preferred. In this country the "Vollmer" patch test is commercially available and has been most commonly employed. The appearance of a reaction to the patch test is different from that resulting from an intradermal test so the reader must be experienced in making interpretations.

In general the patch test is regarded as being less sensitive than the intradermal test, and to be less satisfactory for testing individuals over the age of 12. If the intradermal test is to be used, a standardized preparation of P.P.D. is preferred. However, O.T. is still being used by many with satisfactory results. The cost per dose is extremely small for either one.

The advantages of intradermal testing are: 1. With good technique few reactors will be missed. 2. The dosage and depth of administration can be accurately controlled. 3. Within 72 hours,

the test can be read with precision and may be measured. 4. The test cannot be removed accidentally or tampered with. 5. It is inexpensive.

The disadvantages are: 1. Some people have an aversion to the use of a needle (a good preliminary education program will ensure close to 100 per cent participation in most communities). 2. Special and sterile equipment is necessary. 3. Tuberculin solutions do not maintain potency more than a few days. 4. The test can be given only by trained personnel, usually physicians.

The favorable aspects of patch tests are as follows: 1. No needle is used. 2. No special equipment or sterilization is necessary. 3. The prepared patches remain potent for several months without refrigeration. 4. Under supervision the patches may be applied by volunteers.

Unfortunately, there are also some unfavorable aspects: 1. The patch test is not as sensitive as the intradermal test and some reactors will be missed. 2. The dose of tuberculin cannot be controlled and a few severe reactions occur as well as false negatives. 3. The interval between test and reading is longer than that of the intradermal test. 4. The patch test is more difficult to read than the intradermal test. 5. Precise measurements of the reactions are impossible. 6. The patches frequently become detached either from tampering or by accident. 7. The patch test is more expensive per individual tested.

Those who are planning the program must decide which groups in the population should be tested. Theoretically if one is to discover all infected individuals, everyone in the community should be tested, and in some less populous areas this has been attempted. No one has had the temerity to try it in large cities, however. A sampling of various groups in the population may be practical and valuable if done with expert statistical guidance. Communities vary tremendously and no one formula will fit all communities. It is important that a program to determine infection levels and trends in a community include adults as well as children. Current testing programs so frequently neglect the adult population from which come the bulk of tuberculosis cases.

A testing program limited to school children will give some indication of the amount of active tuberculosis in a community. Again the ideal would be to test all children every year. If all children cannot be tested every year, expert opinion seems to favor annual testing of children entering school, a grade midway, such as the sixth, seventh or eighth, and those about to leave school (usually twelfth graders). This will give some in-

formation on infection rates and will provide some basis for case finding among the contacts of new reactors.

The school testing program offers an opportunity to tuberculin test all teachers, bus drivers, food handlers, custodial and maintenance employees who are in close contact with the children. Although the percentage of active cases in these adults will be small, there are many reports of sharp epidemics of tuberculosis in schools traceable to a teacher or other employee with unsuspected active disease.

Examination of all older children and adults by X-ray without a preliminary skin test is simpler and will reveal conditions other than tuberculosis but provides no basis for epidemiological follow-up. It would be preferable to give tuberculin tests and chest X-rays to everyone in this older group.

Editor's Note: This is the first of two abstracts on the tuberculin test. The second will be the May issue of Tuberculosis Abstracts.

ANNUAL REPORT OF ARKANSAS STATE CANCER COMMISSION

W. R. Brooksher, Secretary

During the fiscal year 1954-1955, 586 patients were hospitalized and 324 received domiciliary care under the program in Arkansas. Payments for domiciliary care were made from funds provided by the Arkansas Division, American Cancer Society. A total of 1,339 patients were received in the seven tumor clinics of the state and 7,700 visits were made by patients to these clinics. There were 4,732 active cancer cases registered in the tumor clinics. Indigent patients received professional services, as indicated, for the treatment of malignancy on a gratis basis by the members of the Arkansas Medical Society who are generously giving of their time and abilities for the care of these patients. The Commission is grateful for this cooperation and expresses appreciation to these physicians, the tumor clinics and staff personnel, to the voluntary workers and staff in the Arkansas Division, American Cancer Society, and to many others who have assisted in the care of the cancer patient in Arkansas.

Error of opinion may be tolerated where reason is left free to combat it.—Jefferson.

Truth crushed to earth will rise again.—Old Proverb.

Personal and News Items

Two Arkansas Physicians have entered the lists for officers this election year.

H. J. Hall, Clinton, is announcing for representative from Van Buren and Woodrow Phillips, Jr., has thrown his hat in the ring for re-election to the School Board of North Little Rock.

H. C. Darnall, Fort Smith, addressed the Booneville Rotary Club on February 14.

O. C. Melson addressed the Young Men's Business Association in Little Rock on February 20 on "Taking Care of Your Heart."

William Luther Newton was honored in his home town of Smackover on February 21st with "Dr. Newton Day."

He is active in his community life in the area which he has served since 1922 when he opened offices in the booming oil town. He is an active member of the Union County Society.

Walter G. Selakovich has recently joined the Cooper Clinic in Fort Smith. He is an orthopedic surgeon and comes from New Orleans.

R. B. Robins, Camden, made the principal address at Hope Rotary Club annual banquet on February 24.

Open house was held at Petty's Clinic in Star City in February to mark the opening of the new 15-room office building. Richard Petty and Mrs. Petty were hosts.

Contributions from physicians in Arkansas to the American Medical Education Foundation, February, 1956: J. H. McCurry, Cash, Arkansas.

F. Walter Carruthers attended the 23rd annual conference of the American Academy of Orthopedic Surgeons at Chicago. As a member of the teaching faculty of the Instructional Course he delivered a lecture on "Treatment of Fractures of the Pelvis and Their Complications."

Max Roy, Forrest City, is newly elected vice president of the Mid-South Postgraduate Assembly of Memphis. Joe Verser, Harrisburg, is retiring president of the organization.

President L. H. McDaniel addressed the Oklahoma Academy of General Practice in Tulsa February 6 on "Medicine of Tomorrow."

James G. Stuckey, Little Rock, addressed the Craighead-Poinsett Medical Society at their February meeting. He spoke on "Proper Handling of Facial Lacerations and Other Injuries."

Lewis M. K. Long has joined the staff in Psychiatry at the University of Arkansas Medical School. He comes recently from studies in Clinical Psychology in Boston. He is originally from the University of Oklahoma.

Four Little Rock physicians took part in the Arkansas Bar Association's annual meeting on February 3rd. The panel discussed testimony, damage award and injury litigation. Taking part were: Joe A. Norton, Kenneth G. Jones, Frank Padberg, and Joseph A. Buchman.

David M. Gould, newly appointed professor and head of the Department of Radiology at the University of Arkansas Medical Center, has assumed his duties here. He succeeds Dr. I. Meschan, who resigned and left the state several months ago.

Dr. Gould came to the University of Arkansas from Johns Hopkins Hospital, where he had been affiliated with the Department of Radiology since 1947.

He is a native of Worcester, Mass., and was graduated from Harvard Medical School in 1939.

Paul L. Mahoney, Little Rock, addressed a clinic held at the University of Alabama Medical Center on "New Concepts of Rhinoplastic Surgery."

J. D. Ashley has moved offices into the Newport Hospital at Newport.

T. H. Hickey, Morrilton, is moving to new offices at East Highway 64 in the near future.

Proceedings of Societies

(Quoted from the Arkansas Democrat)

The Pulaski County Medical Society has established two speakers' bureaus, one to provide speakers for civic organizations, and the other to send doctors to discuss medical subjects before the various county medical societies.

The society has been working closely with the doctors' exchange to provide a doctor at any time for any emergency, regardless of the patient's ability to pay. If a person's own doctor cannot be located, another can be obtained until the regular doctor can be contacted.

The society also has organized a grievance committee to mediate disagreements between patients and physicians—usually over fees.

COLLEGE OF SURGEONS

Some 400 members attended the American College of Surgeons' meeting in Little Rock March 12 and 13 at a sectional meeting. Members were present from Mississippi, Louisiana, Texas, Tennessee, Oklahoma, Missouri and Arkansas.

Warren H. Cole of Chicago, president of the American College of Surgeons, participated in the convention sessions. A symposium on the management of mass casualties was arranged for March 12. Speakers were Lt. Col. James B. Hartgering, Walter Reed Army Center at Washington; Col. Joseph R. Shaeffer of Washington, chief surgical consultant of the office of the Surgeon General, Department of the Army; Truman G. Blocker, Jr., of Galveston, and Curtis Lohr, St. Louis County Hospital at Clayton, Missouri.

A symposium on trauma was held at which Robert H. Kennedy of the New York University College of Medicine and Carl A. Meyer, Washington University School of Medicine at St. Louis were the speakers.

Dr. Cole led a symposium on surgery of the aged on March 13. Others participating included Gilbert O. Dean, Henry G. Hollenberg and Joseph F. Shuffield, all of the University of Arkansas School of Medicine at Little Rock; Gerald H. Teasley of Texarkana, University of Arkansas School of Medicine; and Willard H. Parsons of the University of Mississippi School of Medicine at Vicksburg.

A cancer symposium was held March 13. Speakers included William J. Engel of Cleveland, Ohio, Cleveland Clinic Foundation; I. Meschan,

formerly of the University of Arkansas School of Medicine and now with the Bowman Gray School of Medicine, Winston-Salem, N. C., and William M. Tuttle of Wayne University College of Medicine, Detroit, Michigan.

The meeting closed with a symposium on acute abdomen. Speakers were James M. Mason of Birmingham, Medical College of Alabama, and B. Marden Black of Rochester, Minn., Mayo Foundation, University of Minnesota Graduate School of Medicine.

At a meeting of the Craighead-Poinsett County Medical Society in Jonesboro on March 7th, Marion S. Craig, Little Rock, spoke on "Pre- and Post-Operative Care in Ano and Rectal Surgery."

March 18 was the date of an all-day Postgraduate Seminar held in Texarkana by the University of Texas Postgraduate School of Medicine especially keyed to the needs of the man in general practice.

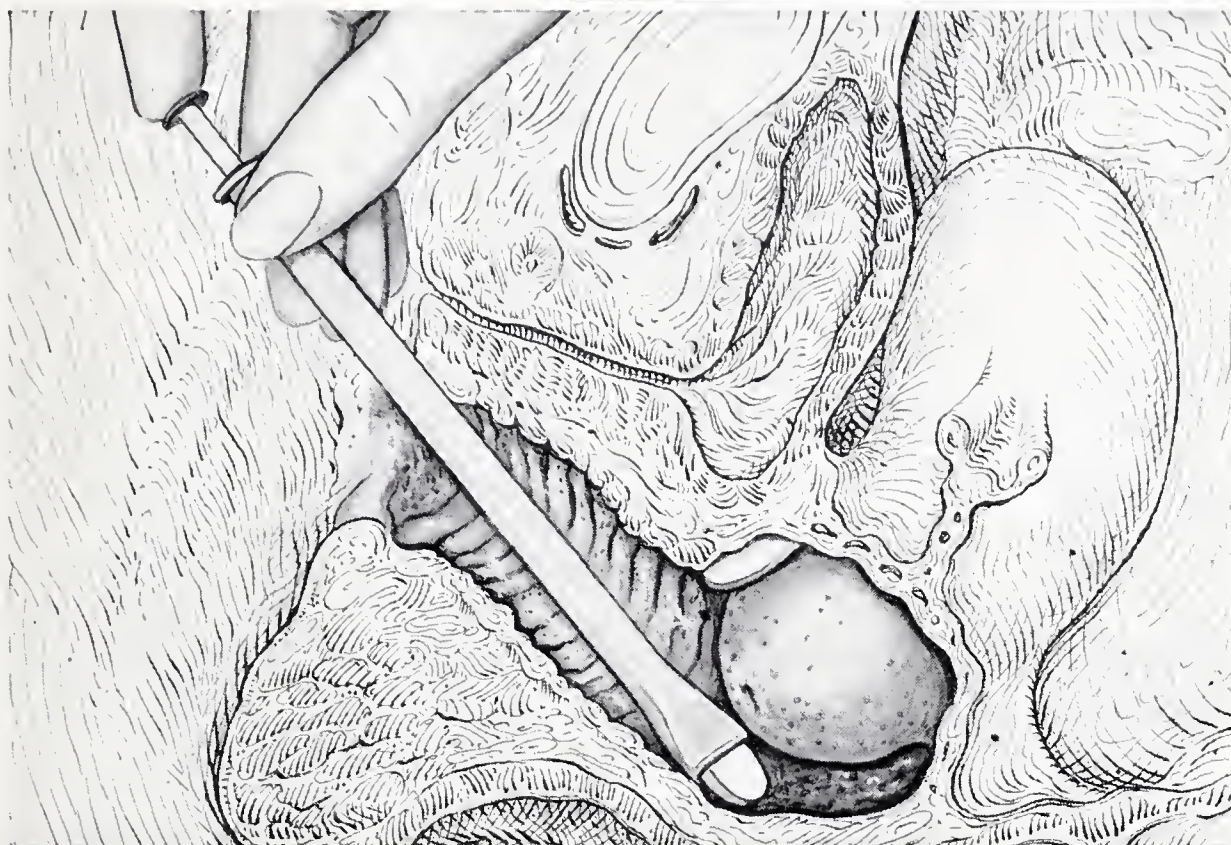
The Franklin County Medical Society held their annual electing meeting at Turner Memorial Hospital in Ozark the 13th of February, 1956.

The following officers were elected for a term of one year: W. G. Hensley, Charleston, president; David L. Gibbons, Ozark, secretary-treasurer; C. C. Long, Ozark, delegate to the A.M.S. where he is vice-speaker of the House of Delegates.

The Sebastian County Medical Society sponsored a diagnostic Heart Clinic in Fort Smith on February 24.

"Community Health Week" was held in Pulaski County March 18-25 under the guidance of the Pulaski County Medical Society. This is the second annual observance.

M. L. Dalton, Brinkley, is president of the Monroe County Medical Society for 1956. Other officers are: Vice President—F. M. Wilson, Cotton Plant; Secretary—Terry Swaim, Cotton Plant. E. D. McKnight, Brinkley, is the delegate to the Arkansas Medical Society and J. P. Williams is alternate.



New Intravaginal Applicator for Improved Treatment of Vaginitis

The restorative treatment of vaginitis with Floraquin is now further improved by a new aid to tablet insertion. Faulty insertion is no longer a failure factor in therapy.

The new Floraquin applicator is designed for simplified insertion of Floraquin tablets by the patient. This plunger device, made of smooth unbreakable plastic, places the Floraquin tablets in the fornices and thus assures coating of the entire vaginal mucosa as the tablets disintegrate. The patient inserts two Floraquin tablets with the applicator in the morning and also two tablets at night, with treatment being continued through at least two menstrual periods. During menstruation it is desirable to increase medication to eight tablets daily to combat the alkalinity of the menstrual flow.

Warm acid douches (2 ounces of 5 per cent acetic acid or white vinegar to 2 quarts of

warm water) may be taken as often as desired for hygienic purposes.

Floraquin contains Diodoquin® (diiodo-hydroxyquinoline, U.S.P.), the safe and effective protozoacide and fungicide. Lactose, anhydrous dextrose and boric acid are included to help restore the normal acid pH of the vaginal secretions. Such an acid vaginal medium then encourages the growth of normal flora and makes the environment unfavorable for pathogens.

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New Floraquin Applicator and commercial package of 50 Floraquin tablets available on request to . . .

SEARLE

P. O. Box 5110, B
Chicago 80, Illinois

The second annual South Arkansas Seminar on General Surgery was held February 26 at Hotel Camden, sponsored by the Ouachita County Medical Society.

The program of the seminar was presented by the Department of Surgery of the University of Tennessee School of Medicine. A round-table luncheon was held and a panel discussion was led by R. H. Patterson.

At its February meeting in Clarksville the following officers were elected for the year: James M. Kolb, president; G. L. Hardgraves, vice-president; G. R. Siegel, secretary-treasurer; W. R. Scarborough, delegate to the Arkansas Medical Society, and R. H. Manley, alternate delegate.

WOMAN'S AUXILIARY NEWS

Mrs. Mason G. Lawson, President of the Woman's Auxiliary to the American Medical Association, attended the A.M.A.'s 11th National Conference on Rural Health in Portland March 8-10 and was the speaker at a banquet on March 9th.

From Portland, she went to New York for a meeting of the Committee on Volunteer Activities of the American Heart Association to which she was recently appointed for a period of two years.

March 13th and 14th, Mrs. Lawson attended a Conference of the Woman's Auxiliary to the Pennsylvania Medical Association in Harrisburg, Pennsylvania. She was the featured speaker at their banquet on March 16th.

BOOK REVIEWS

Current Therapy 1956—Latest Approved Methods of Treatment for the Practicing Physician—by Howard F. Conn, M.D., Houston. Pp. 632, 1956, \$11.00. W. B. Saunders Company, Philadelphia.

This ever-popular work has gone into the 1956 Edition and carries on with the original plan of its *raison d'être*. Re-written by its many collaborating authors it is factual and up-to-date. Even the list of contributors has of a natural necessity, been revised. The book is another milestone of success in a long series of excellent reference works. No change in format, index or general outline has been made.

A Modern Pilgrim's Progress for Diabetics. Garfield G. Duncan, M.D., Clinical Professor of Medicine, Jefferson Medical College; Director of Medical Division, Pennsylvania Hospital and Benjamin Franklin Clinic, Philadelphia.

W. B. Saunders Company, Philadelphia. Pp. 222, February, 1956. \$2.50.

This little book written for popular and widespread lay use is unquestionably at the top in its field. Its presentation to the diabetic patient has not sacrificed one item of scientific accuracy and yet it reads like a novel. It is optimistic but factual and outlines no false promises. An appendix has many diet suggestions, measurements and an excellent glossary of terms, encountered by a diabetic, whether in his physician's office or a hospital is included. This book will sell by the many thousand.

Experimental Tuberculosis: Bacillus and Host. Edited by G. E. Wolstenholme, O.B.E., M.A., M.S., B.Ch. for the Ciba Foundation, London. Pp. 306. 1955. Illustrated. Little Brown & Co., Boston. \$9.00.

Ciba Foundation has undertaken a number of symposia on the experimental approach in medicine and chemistry and presents this volume as a round-table report of conversations concerning nature of the tubercle bacillus. This colloquy is composed of such chapters as the Protein structure, the Chemical structure, the polysaccharide components of the tubercle bacillus and of other chapters concerning the reaction of tissues to the bacillus and of its various components. It is an excellent work for laboratory reference—points out new and unexplored avenues of approach to disease and what it lacks in clinical application is more than made compensated in its theoretical approach and value.



The JOURNAL

OF THE ARKANSAS MEDICAL SOCIETY

PUBLISHED MONTHLY UNDER DIRECTION OF THE COUNCIL

Vol. LII

MAY, 1956

No. 12

THERAPY OF PRESENT DAY RECALCITRANT URINARY TRACT INFECTIONS*

ROBERT LICH, JR., Louisville, Kentucky †

Present day chronic urinary tract infections constitute an entirely different problem than that of no more than 10 years ago. Immediately after the sulfonamide era it appeared that our problems in treating urinary tract infections were over. There was, and there continues, a constant parade of antibiotics and chemotherapeutic agents that seemingly would solve everything and this coupled with sensitivity studies suggested the origin of an exact therapeutic science. But with the advent of time we found that clinical progress and laboratory direction were, on occasion, at variance. It is the purpose of this paper to discuss and attempt clarification of some of these variables. Furthermore, what is said for recalcitrant urinary infections applies equally to similar infections beyond the domain of the urologist.

Chemotherapy and antibiotic therapy have introduced two distinct problems which must be appreciated to intelligently combat present day bacterial infections. First, the production and increasing prevalence of resistant organisms and second, the appearance as pathogens organisms that were previously clinically unimportant semi-saprophytes. Undoubtedly it is these factors or a combination thereof and others yet to be discerned that are responsible for the usually accepted 10 per cent failures in the permanent control of urinary infections.

First, let us consider the problem of increasing bacterial resistance to antibiotics and chemotherapeutic agents. When penicillin first became generally available Selbie⁴ noted that approximately 10 per cent of staphylococci possessed an inherent resistance which could not possibly have been due to previous penicillin exposure. This figure has gradually increased until today more than 50 per cent² of the strains of staphylococci are resistant to penicillin. The primary academic

consideration is whether or not these resistant forms are due to a change in the previously sensitive organism or if the initially resistant staphylococci have attained this prominence. It would seem rather unlikely that the naturally resistant forms could have assumed the proportion of half of all pathogenic staphylococci. Therefore, this increase of resistance must be due to an inherent change in the organism and the evolution of a penicillin refractory group. This latter assumption has been confirmed experimentally by exposing staphylococci to gradually increasing increments of penicillin until the surviving organisms successfully multiply in concentrations of penicillin which would have been initially destructive. It was found, in the instance of penicillin, that this curve of survival was a gradually increasing increment and this "penicillin resistance pattern"² was at distinct variance with the step-like irregular curve of streptomycin or the "streptomycin resistance pattern."³ These two characteristic patterns of resistance for penicillin and streptomycin are well recognized and are of clinical importance. These patterns indicate the rapidity by which resistance can occur and may aid in evaluating newer agents or combinations; i.e., streptomycin and isoniazid. The single step pattern of streptomycin demonstrates rapid resistance wherein resistant bacterial forms may occur in a matter of hours as compared to the multi-step pattern of penicillin in which the process requires months or years.

The mechanism of bacterial resistance to antibiotics is an observable continuous process of evolution or changing physiology to permit survival in the face of adversity. The antibiotic mechanism of bacterial destruction is through interference with essential bacterial metabolism. Hence, bacteria surviving the antibiotic onslaught must effect some accommodation in its metabolic processes or elaborate a neutralizing enzyme which renders the antibiotic inert. The particular surviving bacterium represents the single cell culture of a new race. We have executed, with antibiotics, an ob-

† Professor and Chairman of the Section on Urology, University of Louisville School of Medicine and Senior Urologist, John N. Norton Memorial Infirmary.

* Read before the Pulaski County Medical Society, University of Arkansas School of Medicine, Little Rock, Arkansas, January 9, 1956.

servable process of bacterial evolution and it is fundamentally this factor that provides the changing effectiveness of our antibiotics. These few facts represent but a meager fragment of the story of bacterial resistance to modern antibacterial therapy, but further discussion is not herein possible.

Let us say a few words with reference to a group of bacteria that are assuming ever greater prominence as troublesome pathogens though previously belonged to a non-clinical sphere of relatively unimportant semi-saprophytes. These organisms because of their low position in the evolutionary scale have available metabolic powers to synthesize complex molecules from the most simple. This inherent ability accounts for their adaptability under the adverse circumstances imposed by antibiotic interference with normal physiology. This group consists of the following organisms:

1. *B. proteus*
2. *Ps. aeruginosa*
3. *Coli-aerogenes* group
4. *Staphylococcus*
5. *Enterococcus*

These organisms may be present initially in urinary infections as secondary invaders of limited number and the urine culture may demonstrate, for example an *E. coli* with certain therapeutic sensitivities, but in spite of the exhibition of the recommended drug clinical improvement fails or is short-lived. Our first reaction is that the sensitivity study was not clinically valid. However, often the indicated antibiotic completely destroys the primary infection, but as this organism is eradicated the secondary bacteria continue the clinical symptoms. Actually a re-examination of the infecting organism at this time will reveal an utterly different bacterial picture. All of this can occur in a matter of hours. Hence, we must not rely upon a single culture or a single sensitivity determination when considering persistent infections. Repeated cultural and sensitivity studies may be necessary to direct a successful regimen.

What factors prevent or reduce the potentiality of the production of resistant bacterial forms? First, the use of an effective dose of the specific antibacterial agent that is indicated; second, the continuation of medication beyond the immediate period of cessation of clinical symptoms; and third, the elimination of such factors that interfere or prevent therapeutic efficiency. The following factors are instrumental in hindering therapeutic efficiency:

1. Foreign bodies
 - a. Calculi

- b. Catheters
 - c. Intra-luminal tumors
2. Urinary stasis
3. Deficient host resistance
 - a. anemia
 - b. carcinoma with inanition
 - c. non-viable tissue
 - d. undrained pus
4. Focal infections

The catheter is probably the most common agent responsible for resistant urinary tract infections. Our expectation of antibiotics to maintain a sterile urine in the presence of a retention catheter is due more to indiligence than sound judgment. The catheter initiates the infection through urethral and vesical neck trauma and the continued use of the antibiotic effects a resistant organism which upon catheter removal defies destruction. The solution to this problem is two fold: 1) to avoid the misuse of the urethral catheter and 2) to resort to active and frequent bladder lavage during the period of catheter retention. The particular solution for vesical irrigation is of little importance though a 0.5 per cent acetic acid solution is both simple and effective in minimizing calcium precipitation in the bladder and catheter. Tidal drainage offers much to protect these patients from bladder infections and needs greater consideration.

The necessity of removing urinary calculi, intra-luminal tumors and eliminate urinary stasis is obvious and must be accomplished if any hope is held for the permanent sterilization of the urinary tract. The subject of "deficient host resistance" is apparent since the majority of the chemotherapeutic and antibiotic agents are bacteriostatic and depend upon the hosts' ability to eradicate the infection which is held in abeyance by the agent in use. Focal infections act as a constant source of reinfection and their continued presence in the face of antibiotic therapy results in a substantially resistant bacterial flora. In short, a thorough study of the problem is essential followed by the intelligent use of antibiotics otherwise the antibacterial agents become more detrimental than beneficial.

The proper methods of obtaining urine samples for culture and study are important. It is axiomatic that unless the male cannot void the urine should never be obtained per catheter. The urine specimen must be collected during the mid-period of the uninterrupted urinary stream. To introduce a catheter seeds the bladder with urethral bacteria and may potentially complicate the cultural picture or initiate a urinary infection. In the

female, for anatomical reasons, catheterization is mandatory though its indiscriminate use must be condemned. A portion of the urine is used for culture and sensitivity tests and the remainder is centrifuged for microscopic study of the sediment. It is wise to compare the cultural findings with the findings in the sediment since in this way it is possible to determine the presence or absence of secondary invaders which on occasion may not be culturally evident.

In chronic infections antibiotic therapy should be initiated only after sensitivity studies dictate the drug of choice. There is nothing to be gained by instituting immediate therapy when the situation has been of longstanding. To institute ineffective therapy may induce a regrettable instance of bacterial resistance. Also, to initiate therapy without knowledge of the sensitivity tests may change the picture so as to nullify the accuracy of the sensitivity findings and add to the confusion already present.

The various chemotherapeutic and antibiotic agents may be divided into bacteriostatic and bactericidal groups:

Bactericidal	Bacteriostatic
Penicillin	Sulfonamides
Streptomycin	Chloramphenicol
Erythromycin	Tetracycline group
Polymyxin	Furadantin
Neomycin	
Bacitracin	

The bactericidal agents, as a group, possess greater toxic properties for the host. Polymyxin, neomycin and bacitracin are sufficiently toxic that these substances must be used with caution, but at the same time they are not unmanageable and should be employed whenever the situation merits their relative risks. When using these drugs it is essential that the patient's renal status be relatively normal. If during their use azotemia appears or the urinary output falls below 500 cc. per 24 hours the drug must be promptly discontinued. Renal disturbance secondary to these drugs is reversible, but auditory changes are not and their

incidence is increased in the presence of intrinsic renal disease.

Average daily dosages given intramuscularly in 4 to 6 equally divided doses are given below:

Polymyxin	4 mg. per kg.
Neomycin	10 mg. per kg.
Bacitracin	1000 units per kg.

As stated previously in chronic infections the antibiotic used should be dictated by the results of the sensitivity tests. Below are listed some of the more useful chemotherapeutic and antibiotic agents and/or combinations in the treatment of these recalcitrant infections:

B. proteus	neomycin Furadantin chloramphenicol + sulfonamide
Ps. aeruginosa	Polymyxin streptomycin + oxytetracycline
Coli-aerogenes	polymyxin or neomycin chlortetracycline streptomycin + chlortetracycline or sulfonamide
Staphylococcus and Enterococcus	bacitracin erythromycin + chloramphenicol or streptomycin

Summary

Some of the factors contributing to chronicity of urinary infections are discussed. A group of organisms commonly found are listed and the most useful antibiotic agents briefly presented. The necessity of repeated cultural and sensitivity tests in recalcitrant urinary infections is emphasized.

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THE SIGNIFICANCE OF BRONCHIAL OBSTRUCTION*

FRED J. GRAY, JR.

The symptoms of obstruction, wherever they arise are so dramatic that they cry out for immediate attention. This is particularly true in gastrointestinal obstruction, urinary obstruction, glaucoma, common duct obstruction, pancreatic obstruction, embolism, etc. This situation is fortunate because of the serious disease which they signal. But the symptoms of bronchial obstruction, while they may be dramatic, often are not. Yet bronchial obstruction is a very serious problem which can cause severe, acute, recurrent, or chronic pulmonary disease resulting in prolonged disability, loss of earning power, and permanent broncho-pulmonary damage beyond the original extent of the disease.

Perhaps the most significant factor in bronchial obstruction is the relatively high percentage in which the etiology is neoplasm, and this of course demands immediate investigation including bronchoscopy, bronchography, sputum examinations, X-ray examinations including planigrams, and exploratory thoracotomy if no definite diagnosis has been made. One cannot emphasize too much exploratory thoracotomy because with present day surgical techniques and anesthesia techniques it is a safe operative procedure and will lead to a diagnosis.

The symptoms of cough, fever, or wheeze are unfortunately also the symptoms of many respiratory infections and are therefore often minimized. However, cough which is persistent or fever which is recurrent, or wheeze which is persistent and localized to one side or one area with perhaps added hemoptysis, are symptoms which cannot be ignored.

One should not wait for such dramatic symptoms as shortness of breath, high fevers, severe chest pain, weight loss or loss of appetite before investigations are carried out.

The purpose of this paper is to discuss the importance of bronchial obstruction in a group of pulmonary diseases, and to indicate to some extent what plan of treatment or investigation should be carried out.

Pneumonia

The diagnosis of pneumonia today is quite confused by two factors: 1—the antibiotics, and 2—the recognition of primary atypical or "virus" pneumonia. The first tends to mask the disease; the second, to act as a "raw" file into which go

those respiratory problems we cannot readily explain. Both present hazards that must be recognized. The relief of symptoms by antibiotics may postpone a necessary X-ray of the chest and diagnosis of an unsuspected more severe pulmonary disease which requires early investigation and/or treatment. To label lesions unresponsive to penicillin or those with perihilar infiltration or mass as "virus pneumonia" may start a course of procrastination that lasts longer than was originally intended and which may jeopardize the safety of the patient. Actually "virus pneumonia" comprises a relatively small percentage of pneumonias.

Pneumonias that do not respond rapidly to antibiotics or those with a "peculiar" unilateral perihilar location indicate much more serious disease than pneumonia in the vast majority of cases, and exhaustive investigation to the point of exploratory thoracotomy is indicated.

Lung Abscess

The importance of bronchial obstruction in lung abscess is associated with the development of the abscess. Damage to the bronchus from the infecting agent may lead to obstruction and actual abscess formation with fluid level on X-ray. If no bronchial obstruction is present then the area of pneumonia may clear without complication. This obstructive process is responsible for the poor results in bronchoscopic drainage of lung abscesses, but bronchoscopy is necessary to rule out the possibility of neoplasm.

Treatment of lung abscess should consist of **intensive** antibiotic therapy for four to six weeks with the agent of choice, usually an agent with a broad spectrum. If clearing is not complete in that time resection is advised. Usually about 60 per cent of abscesses will heal with antibiotics alone if treatment is intensive, but about 40 per cent will require surgical intervention.

Bronchiectasis

While the disease bronchiectasis seldom is responsible for bronchial obstruction, bronchial obstruction often causes bronchiectasis. Etiologic factors may be foreign body, neoplasms, stenosis from chronic infection in adjacent lymph nodes, or tuberculous endobronchial disease.

Foreign Body

Aspiration of a foreign body may produce quite dramatic symptoms which demand immediate bronchoscopic removal. Presence of a wheeze,

* Received for Publication February 15, 1956.

dyspnea, limitation of excursions, severe cough, a history of aspiration or X-ray visualization of obstructive emphysema when the obstruction is incomplete or atelectasis when it is complete, are signs that usually lead to immediate attention. On the other hand, small foreign bodies may be aspirated by children who cannot give an adequate history or fail to do so, and it occasionally is the situation in adults. In these circumstances, recurrent episodes of pneumonitis, hemoptysis, fever of unknown origin, and development of bronchiectasis may result. It is in this group that vigilance is important.

Lymph Node Compression

Particularly in the right middle lobe, but in lobes elsewhere as well, hyperplasia and enlargement of hilar lymph nodes in response to infection may produce bronchial obstruction, prevent clearing of the infection, and thus set up a vicious cycle that leads to atelectasis or bronchiectasis in a given area of the lung. We must also be aware of a not uncommon situation in which calcification in a node, the end result of tuberculosis or other chronic inflammatory disease may cause compression or actual erosion of a bronchial wall resulting in: expectoration of the "stone" and healing or 2—expectoration of the broncholith and stenosis or complete obstruction from scar, or 3—the extrusion of a large broncholith into the lumen of a bronchus with resulting obstruction because it is not expectorated. Broncholithiasis is not a benign disease.

Inflammatory Stenosis

This group includes tuberculosis, the most important etiologic disease. Some degree of endobronchial tuberculosis is always present although only about 20 per cent is visible in the major bronchial divisions on bronchoscopy. Resulting tension cavities, blocked cavities, or tuberculous bronchiectasis are best treated by excision, either segmental resection or lobectomy. In the other group of inflammatory stenoses the etiologic agent is almost always impossible to determine because all that is seen is the end result of the active disease, and so we know very little about the possible etiologic agents.

Asthma

Patchy areas of pneumonitis complicating asthma are not uncommon. When extensive, bronchoscopy may be a helpful aid although bronchoscopy in the acute phase of an episode is to be avoided if possible. At times if a given area is repeatedly the site of a pneumonitis, pulmonary resection may improve the situation, though results are not always dramatic, permanent, or even helpful.

Summary

Bronchial obstruction is as important and as serious as obstruction in any other hollow viscus. Obstruction which does not clear immediately should be investigated to the point of exploratory thoracotomy because of 1—the possibility of neoplasm, and 2—the serious nature of resulting permanent pulmonary disease.



REPORT ON CARCINOMA OF THE CERVIX TREATED AT THE SOUTH ARKANSAS TUMOR CLINIC*

GEORGE C. BURTON, NEIL E. CROW and JOE A. NORTON

This is a report of sixty-three cases of carcinoma of the cervix treated entirely at the South Arkansas Tumor Clinic, El Dorado, between 1947 and 1950, with brief comment concerning carcinoma of the cervix.

Method

The treatment given all patients consisted of external X-ray treatments to a total dosage of about 12,000 roentgens, in air, which was divided among six external pelvic ports. Generally, treatments were given daily, except Sundays, using

a beam of HVL of 1 mm. cu., 50 cm. distance, and portals of 10 x 15 cm. The usual daily increment was 400 roentgens in air. The patients also received either transvaginal X-ray treatments and/or intracavitary and/or colpostatic radium treatments. A minimum tumor dose of 5,000 roentgens (radium plus X-ray) was delivered to the tumor within the pelvis.

No patient has been classified as a five-year survival who has not lived five years or longer free of disease. Patients who died of any cause before the lapse of five years were counted as carcinoma deaths. Patients who died within one

* Received for Publication March 1, 1956.

month of the beginning of treatment were considered as deaths due to irradiation, even though strictly this was not the case. No patient was included in this group who had any form of surgery or irradiation treatment to the cervix prior to coming under our care. All patients included were treated by one or more of the authors. Not all patients completed the course of treatment that was planned, but if she took only one treatment, she was included in the statistics. Any patient who lived five years free of disease was considered a five-year survival.

The clinical staging of carcinoma of the cervix used is the Schmitz classification. This classification differs slightly from the League of Nations classification, which is in more current use. The difference, primarily, is that the League of Nations classification is more liberal in stage one carcinoma of the cervix. A considerable number of League of Nations stage one carcinomas of the cervix would be placed in the Schmitz group II. A brief comparison of these two classifications follows:

Schmitz	League of Nations
Stage 1: Cervix only—less than 1 cm. in size	Cervix only
Stage 2: Cervix only—more than 1 cm. in size	Cancer may extend to fundus, upper two-thirds of vagina, or parametrium, but not to pelvic wall
Stage 3: Parametrium or upper vagina	Parametrium involved to the pelvic wall
Stage 4: Distant metastases or mucosal involvement of bladder or rectum	Distant metastases or mucosal involvement of bladder or rectum

The carcinoma in situ classification was also used. In this manner the sixty-three cases, with ages varying from sixteen through eighty-five years and averaging 49.4 years, were classified as follows:

- 11 cases were carcinoma in situ.
- 9 cases were carcinoma Schmitz group I.
- 21 cases were carcinoma Schmitz group II.
- 16 cases were carcinoma Schmitz group III.
- 6 cases were carcinoma Schmitz group IV.

Results

Of the sixty-three patients, 37—58.7 per cent—are living five years or more after completion of treatment and are apparently free of disease. If the cases of carcinoma in situ are omitted and only the invasive carcinoma included, the absolute five-year survival is 48.1 per cent. Six of the cases—9.5 per cent—have been lost to follow-up and are considered to be dead of carcinoma. One was a case of carcinoma in situ but no case of

carcinoma in situ is known to have died of carcinoma during the five-year follow-up period. One patient died within one month of beginning treatment. As stated earlier, these deaths have been considered, for statistical purposes, as possibly due to irradiation, giving a mortality from radiation for this series of 1.6 per cent. The survival rate for each group has not been computed, since the number in each group is so small. Generally, however, the highest rate of survival is in the early groups, as is to be expected. Only one Group IV carcinoma of the cervix is alive and well five years after treatment.

Discussion

After the age of 40, carcinoma of the cervix is the most frequent cancer affecting the female, excluding skin carcinomas. Its course is an old and familiar subject to us all, with the disease continuing to kill thousands of women each year. This fact makes any serious discussion of the disease pertinent. The cause of cervical cancer is unknown. The most frequent ages of involvement are forty to fifty years, and the tumor may involve any female. Pathologically, 95 per cent of cervical cancers are squamous cell carcinomas, with the other 5 per cent adenocarcinomas. The tumors may grow out from the cervix and form bulky masses, or they may grow into the cervix and form ulcers. A cratered lesion might result from ulceration in a bulky tumor. The tumor most frequently spreads by direct growth or via the pelvic lymphatics. Any treatment regimen must include the surrounding local tissues and regional lymph nodes. The symptoms vary with the age and spread of the tumor.

The statistics from this small series of cases compare favorably with those of other reports which have been treated with similar techniques. Generally, the results reported are more favorable in private medical centers than in teaching medical centers, and are proportional to the relatively greater number of stage one and stage two carcinomas seen in private practice. Schmitz reports a series of 499 cases of carcinoma of the cervix which were treated at Mercy Hospital Institute of Radiation Therapy in Chicago between May, 1933, and May, 1945. A total of 188 of these cases were treated similar to the treatment used in our series, and in these 188 cases, Dr. Schmitz had a five-year survival of 43.6 per cent. MacDonald reports a series of 147 cases of invasive carcinoma of the cervix with an overall survival rate of 51 per cent. Scheffey at Jefferson Medical College reports a series of 458 cases of cervical cancers with a 98.5 per cent follow-up. His

cases were grouped according to Schmitz classification also, and were treated similarly to the series reported here, with an absolute five-year survival rate, free of apparent disease, of 47.6 per cent. McCormick reported from Canada on a very large series of carcinoma of the cervix with an absolute survival rate of 49 per cent. In general, stage one carcinoma of the cervix has a 72 per cent five-year survival, stage two has a 56 per cent five-year survival, stage three has a 30 per cent five-year survival, and stage four has a 7 per cent five-year survival. The overall survival of all invasive carcinoma of the cervix varies from 43.6 per cent to 5 per cent, depending on the distribution among the various stages.

Even now, there is still too often controversy as to the best method of treatment of carcinoma of the cervix, as regards surgery or irradiation. A survey of the literature will show that there may be some excusable controversy, particularly in younger patients, as to which of these methods of treatment is superior in Schmitz stage I or II lesions or in League of Nations stage I lesions, for in those cases the best surgical results and the best irradiation results are about equal. Even here, though, the surgical cases must be very carefully selected and the surgery must be very radical, while there is practically no need to refuse radiation treatment, which gives equally good results. It is inexcusable to allow any controversy to delay radiation treatment to a patient suffering from any of the advanced stages of cervical cancer, for numerous statistics show that cure or palliation, depending upon the stage of disease, is superior with properly applied radiation treatment as opposed to surgical treatment.

Morbidity and complications were not studied as to incidence since this series is so small. Generally, however, these are related to the bladder and rectum and are, for the most part, transitory in nature. None of these cases has incurred any pathological fractures. However, further statement should be made concerning the morbidity of properly applied deep radiation treatments. Many doctors and most patients seem to think of deep radiation treatment as easy, painless, and perfectly safe. Patients are too often led by their doctors to expect absolutely no ill effect from the deep irradiation necessary to cure carcinoma of

the cervix, except perhaps some nausea and vomiting. Deep irradiation is a formidable procedure, and does carry definite morbidity and about a 2 to 3 per cent mortality. There may be severe irradiation proctitis and possibly irradiation cystitis, which is usually transient, but which may be very difficult to handle. The nausea and vomiting are usually fairly easy to control although they may become so severe as to interfere with proper treatment. A definite irradiation epithelitis of the skin will occur, and may vary from simple erythema to a blistering reaction, and may heal with tissue atrophy. Bone damage is a possibility although it does not usually occur with modern methods of treatment. Some intestinal and vaginal scarring does usually result. Carcinoma of the cervix is a serious disease. Its treatment by radiation must be thorough, and the follow-up of the patient must be regular and intensive. Above all, the radiation treatment should be given by one who is trained in modern irradiation techniques and who is aware of the morbidity of this method of treatment.

Summary

A small series of cases of carcinoma of the cervix, treated at the South Arkansas Tumor Clinic in El Dorado, has been presented, together with a brief comment on carcinoma of the cervix.

These were treated by radiation and the absolute five year survival for the entire group was 58.7 per cent. If carcinoma in situ cases are excluded the survival rate is 48.1 per cent. Six patients, 9.5 per cent, were lost to follow-up and the mortality from treatment was considered to be 2.3 per cent.

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NOTE: The authors wish to express their appreciation to Dr. H. D. Kerr, St. Michael's, Maryland, for his help in the preparation of this paper.

— ★ Editorial ★ —

The Association of American Physicians and Surgeons is sponsoring the 11th Annual Essay Contest for High School pupils, for 1957. There are good reasons for the individual county medical societies to call attention to this contest, and to support it on a local level. Several of these contests have been sponsored by various county societies in Arkansas, and it has proved an effective means of persuading high school pupils, and teachers, to think, and think clearly, on medico-economic-governmental lines.

The Association supplies packaged material from libraries everywhere, giving attention to the conservative side of medicine's fight against governmental domination. With this information in the hands of the nation's youth, and some of their teachers, there can be but one result — a wider understanding of the "Free Enterprise System."

County secretaries are advised to write Dr. Mal Rumph, Chairman, A.A.P.S. Essay Committee, Suite 318, 185 N. Wabash Avenue, Chicago, Illinois.

A number of auxiliaries to the County Medical Societies took occasion to celebrate Doctor's Day for their husbands.

The occasion adopted was March 30, when a country doctor, Crawford W. Long, first used ether for a surgical anesthetic back in Georgia, in 1842.

In Pine Bluff carnations were pinned on their doctors as the rounds were made at the Davis Hospital. A dinner at 7 completed the festivities.

Benton County decided to make the occasion more grand by honoring A. L. Peacock, Gentry, the oldest practicing physician in the county society and one of its Past Presidents.

At Hot Springs, Mayor Floyd Housley proclaimed the day "Doctor's Day" and the Ladies of the Auxiliary put flowers in the various churches to mark the occasion. Some of the hospitals served coffee and doughnuts to the busy physicians.

The Boone County group went formal with a dinner program at Springlake and had the dentists join the party. The Boone County Memorial Hospital personnel supplied red carnations for their staff members for the event. Mayor Raulsten assisted with a proclamation for the day.

At Magnolia, Mayor Ed Williamson proclaimed Doctor's Day for all Columbia County doctors.

The "Brinkley Citizen" reminds us that they have had Doctor's Day since 1951, when the then Governor Sid McMath proclaimed Doctor's Day for Arkansas and Brinkley wives have not missed an opportunity to honor their physicians on the same date since that time.

The state press was full of pictures on the subject.

Arkansas' Mrs. Mason Lawson is to speak at Myrtle Beach, South Carolina, in May at the annual convention of the Medical Auxiliary to the South Carolina Medical Association. "Our Mona" is bringing credit to the Woman's Auxiliary, to her state and to herself. The **Journal** gives her the heartiest of thanks and congratulations.

Arkansas

TRAVELING

And Clipping Bits Here and There

J. H. McCurry, Cash, says—

There is an old fable that says, "A man who sought happiness was told to find one who was completely satisfied with life and get his shirt and wear it, and happiness would come to him who made the search. After long years of search the completely happy man was found, but he had no shirt."

It is not the big things we do for people that make them our friends, it is the everyday little thing, the cheery smile, the helping hand, the ever ready words of praise or encouragement.

I will offer this advice: Learn to like everyone with whom you come in contact, envy no one their station in life, or their possessions.

According to geography, there are no more worlds to discover, but each of us must discover the little world in which we live, and before we are a complete success, we must conquer ourselves, our tongue, our temper, our greed, and our love of self must be softened by a true regard for the feelings of others.

When we have discovered ourselves we are ready for that broader world in which we live.

Traffic safety has become one of the most urgent challenges to the American public. Last year's toll: 38,300 killed; 1,350,000 injured, and

an economic loss of nearly five billion dollars—the worst record in 14 years.

—Secretary's Letter: George Lull

Both cities and states have been willing to pass on the onus of heavy taxation to the federal government, reasoning that there is no escape from Uncle Sam. But they have produced a Frankenstein that is destroying financial and political independence. Every federal "dole" and grant has strings of power . . . federal power . . . attached, and it strengthens the hands of some federal bureaucrat. Our cities and states have sold their heritage for a mess of federal pottage.

Would it not be wise for some city to have the courage and vision to assess enough taxes to be independent of Washington, to provide total, first class services to its citizens with its own money, and to become solvent in its own right? Perhaps such a city of leadership would attract more industries than a city that has to go begging every time something is needed.

—G. Wilse Robinson, Jr.

From a Recent Bulletin of the Polio Foundation, April '56:

The following compromise or emergency dosage schedule of Salk vaccine coming into the physician's private practice seems warranted under current conditions of supply, discussed below:

1. Do not give "booster" shots between now and July 1. There is minimal risk if, in fact, any at all, in giving primary or booster shots **during** the polio season.
2. Use all available vaccine immediately. Do not save it for "second shots," even though a sterilely punctured vial of vaccine can be kept under refrigeration for an indefinite length of time without impairing either safety or potency of the vaccine.
3. The increasing supply of vaccine should be depended upon for second injections in 1956. The exact interval recommended between the first and second doses is not critical, so long as it is not **less** than two weeks. In fact, longer intervals seem to be advantageous. Therefore, the second dose may be given at any time without losing the benefit of the first.

Long Memorial

The citizens of Georgia owe a debt of gratitude to Frank Boland, M.D., Jefferson, Georgia, who devoted much of his time while he lived to establishing that Dr. Crawford W. Long was the

first to administer ether for surgical anesthesia. It was he who inspired the people of the town of Jefferson and the state of Georgia to acquire the property on which stood the small office building wherein the first anesthetic was given in 1842.

Through the joint efforts of Dr. Boland, Governor Talmadge and the physicians and citizens of Fulton County and the state of Georgia the old building was purchased and renovated to its former state.

The responsibility for the maintenance of this building will be delegated to the Georgia State Medical Association.

This museum and memorial to one of Georgia's most outstanding citizens, one who helped ease the pain of surgical procedures, is a most praiseworthy project and on a par with Michigan's memorial to Dr. William Beaumont on Mackinaw Island.

FROM 535 N. DEARBORN

All Aboard for AMA's Annual Meeting in Chicago!

Dr. Murray to Assume AMA Presidency in June

Formal presentation of the American Medical Association's presidential gavel to Dr. Dwight H. Murray of Napa, Calif., will be made at the Inaugural Ceremony Tuesday evening, June 12, in the grand ballroom of Chicago's Palmer House. One of the featured attractions will be choral selections by the Bluejacket Choir of the U. S. Naval Base at Great Lakes, Ill.

Plans are being completed to telecast part of the inaugural program.

AMA Plans Civil Defense Meeting

The National Medical Civil Defense Conference, sponsored annually by AMA's Council on National Defense, will be held Saturday, June 9, at Chicago's Palmer House, just prior to the opening of the 105th Annual Meeting.

Although final arrangements have not been completed, the Council reports that a special feature of this year's program concerns the availability and operation of the Federal Civil Defense Administration's 200-bed emergency civil defense hospital. FCDA officials will discuss basic plans dealing with the allocation, distribution and utilization of the hospital units. Staffing patterns and actual operating procedures by professional and other personnel will be discussed on the basis of data gleaned during field tests conducted in





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respiratory infections

January and his associates¹ have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.



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¹January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.



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April by the Army Medical Corps at Fort Meade, Md., in which representatives of national health and medical organizations participated.

Also on the program will be appropriate films on technical medical subjects related to civil defense and presentations by outstanding authorities in the field.

Physicians planning to attend AMA's Annual Meeting are urged to come a day or two earlier to attend this valuable civil defense meeting.

Special "Common Cold" Transcriptions

The American Medical Association has announced plans for sending a special "bonus" electrical transcription dealing with the common cold to all radio stations in the country which have broadcast Association health transcriptions during the past two years. The platter will have a 15-minute program on each side based on tape recordings taken at a symposium on the common cold held in February in New York by the Common Cold Foundation.

Approximately 500 discs will be distributed directly to radio stations or through 13 state distributors—the medical societies of California, Florida, Kentucky, Louisiana, Massachusetts, Michigan, New Mexico, North Carolina, Oregon, Pennsylvania, Tennessee, Texas, Virginia—and Alaska.

THINGS TO COME

AMERICAN MEDICAL ASSOCIATION

Chicago — June 11-15, 1956

SOUTHERN MEDICAL ASSOCIATION

Washington, D. C. — Nov. 12-15, 1956

ARKANSAS ACADEMY OF GENERAL PRACTICE

Little Rock — Oct. 17-18, 1956

RESOLUTION

WHEREAS our community has been saddened by the passing of Dr. Randolph Tucker Smith, our valued co-worker and a faithful member of the Pulaski County Medical Society, the Arkansas Medical Society, and the American Medical Association, since 1929, we, the members of the Pulaski County Medical Society, mourn and deeply regret his sudden departure.

WHEREAS Dr. Smith won the respect of his colleagues in his chosen profession of surgery and his long tenure of teaching at Arkansas School of Medicine. His integrity was unquestioned.

He stood unflinchingly for the courage of his convictions. He was interested in his community and took an active part in such organized civic forces as the Chamber of Commerce. His wide variety of interests in many fields gained friends both within and outside his profession. His compassion toward suffering humanity expressed itself in manifold deeds of kindness through many years.

THEREFORE, be it resolved that the Pulaski County Medical Society express to his family the esteem in which he was held as a member of this Society and its heartfelt sympathy to the family at the untimely loss which it has sustained;

BE IT FURTHER RESOLVED that a copy of this resolution be made a matter of record in the minutes of the Pulaski County Medical Society, that a copy be sent to the family, and a copy to the Journal of the Arkansas Medical Society.

This resolution is respectfully submitted to the members of the Pulaski County Medical Society by your committee:

Alan G. Cazort, Chairman

Carl A. Rosenbaum

Fay H. Jones

Approved unanimously by the Pulaski County Medical Society.

ANNOUNCEMENTS

Applications for certification (American Board of Obstetrics and Gynecology) for the 1957 Part I Examinations are now being accepted.

All candidates for admission to the Examinations are required to submit with their application, a typewritten list of all patients admitted to the hospitals where they practice, for the year preceding their application.

Applications must be made to the Secretary prior to October 1, 1956. Write: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

The Fourth International Congress on Diseases of the Chest of the American College of Chest Physicians will be held in Cologne, Germany, from August 19 to August 23, 1956, under the patronage of Federal Chancellor Dr. Konrad Adenauer. The first Congress after the war was held in Rome in 1950, the next one in Rio de Janeiro in 1952 and the third one in Barcelona in 1954. Eighty-six countries will send their representatives.

Prof. Dr. med. Dr.h.c. Gerhard Domagk will be the President.

The main subjects which will be discussed at the Congress deal with the problems of coronary diseases (diagnosis, pathophysiology and surgery), industrial diseases of the chest, tuberculosis, lung and heart function and tumors of the mediastinum. Several outstanding foreign and German scientists and clinicians will present papers on these subjects. This year's Congress will be held with special reference to surgery of coronary diseases. But other presentations in the field of diseases of the chest will be accepted. The official languages for the Congress are: English, French, Spanish and German.

For more detailed information and inscription, write: Secretariat of the Congress: Fourth International Congress of the American College of Chest Physicians, Koln-Deutz, Germany, Messeplatz.

The Surgeon General of the United States Public Health Service, Dr. Leonard A. Scheele, announces that qualified physicians and other professional health personnel actively engaged in public health practice and preventive medicine are being encouraged to apply for commissions in the Service's expanding Commissioned Reserve.

Dr. Scheele said the Commissioned Reserve is being expanded to increase the nation's readiness to meet the unusual public health demands of national emergencies and that the Public Health Service is interested in encouraging greater participation in the program by professional groups. Physicians, nurses, sanitary engineers, and dentists make up the majority of officers now in the Commissioned Reserve.

In the event of national emergencies, the Surgeon General explained, the Commissioned Reserve, composed of qualified professional health personnel, would have the opportunity of serving their country in the capacities for which their professional training and experience have fitted them.

Commissioned Reserve officers will be called for emergency duty primarily to reinforce the staffs of official State and local health agencies and to augment the Public Health Service operating staff.

Scheele also pointed out that no Commissioned Reserve officer will be called to emergency active duty, with the exception of volunteers, unless the situation is publicly recognized as requiring such action.

Write to the Surgeon General, Public Health Service (DP), Washington 25, D. C., for information about the Commissioned Reserve.

Obituary

ISAAC NEWTON McCOLLUM, 89, of Conway, a practicing physician 60 years, died at a Little Rock hospital on March 16.

Dr. McCollum began his practice at Greenbrier after his graduation from the Louisville Medical School in 1894. He removed to Conway in 1907 and retired in 1954.

He was born at Huntington, Tenn., and was a son of Thomas Marion and Sarah Jane Bingham McCollum. He received his early education at Conway.

He was in the Army Medical Corps in World War I and retired from the Army Reserve April 1, 1953.

He was a member of the Southern, Arkansas and Faulkner County Medical Societies. He was a member of Green Grove Masonic Lodge, Conway Chapter of Royal Arch Masons, Conway Council of Royal and Select Masters, Bendemeer Grotto, the Woodmen of the World and the Ancient Order of United Workmen. He was a Methodist and a former chief of staff of the Conway Memorial Hospital. He served on the Conway School Board 20 years.

He is survived by his wife, Mrs. Nora Thompson McCollum, whom he married June 28, 1910; five sons, two daughters, a sister, 19 grandchildren and 18 great-grandchildren.

Burial was at Oak Grove Cemetery.

D. M. G. FRAILEY, 87, last of the old-time family doctors of the hill country, died at his home in Harrison on March 18, 1956.

Born December 10, 1868, in Thompkinsville, Kentucky, Dr. Frailey attended school at Valley Springs and Rally Hill. On his return from medical school, he settled in Mount Judea, Newton County.

Dr. Frailey was holder of the Arkansas Medical Association 50-year service pin, and an active member of the Arkansas Medical Society.

He was married in July 1893 to Alice Nichols, who died in 1933.

During World War II Dr. Frailey moved to Harrison. His failing eyesight forced his retirement in 1949.

Surviving are three daughters, eight grandchildren, 16 great-grandchildren, three great-great-grandchildren. Burial was in the Lurton Cemetery.

RANDOLPH T. SMITH, 57, of Little Rock, died of a heart attack while writing friends in Fort Smith on March 22. He was ill for only a few minutes.

A native of Arkansas, he was born June 25, 1899, and had practiced medicine in Little Rock 28 years. He formerly lived in Camden. Dr. Smith graduated from Washington and Lee Uni-

versity where he was a member of Sigma Chi Fraternity, and received his medical degree from Johns Hopkins School of Medicine in Baltimore.

He was a member of the Second Presbyterian Church, the Pulaski County Medical Society and the Arkansas Medical Society. At one time he was professor of surgery at the University of Arkansas Medical School.

Survivors include his widow, Mrs. Willie Bell Gale Smith; a son and a daughter.

Dr. Smith took an active interest in the public affairs. He also enjoyed many hobbies and at the time of his death was secretary of the Arkansas Numismatic Society.

Burial was in Roselawn Cemetery.

TUBERCULOSIS ABSTRACTS

A Review for Physicians

ISSUED MONTHLY BY THE NATIONAL TUBERCULOSIS ASSOCIATION

REPRODUCED FOR ARKANSAS PHYSICIANS BY THE ARKANSAS TUBERCULOSIS ASSOCIATION

"A CHRISTMAS SEAL SERVICE"

THE TUBERCULIN TEST

By FLOYD M. FELDMANN, M.D.

Medical Director, National Tuberculosis Association

NTA Bulletin, November, 1955

Any community tuberculin testing project can best be handled by a central committee with wide representation including the medical society, the tuberculosis association, the hospitals, the health department, the schools, the social agencies, the nursing groups, the Parent-Teachers Association, and any others who may have some direct or indirect interest. After a general plan has been agreed upon, a smaller group can serve as an advisory group but better results will be obtained if everyone interested directly has a chance to be fully informed and has a part in deciding on the plan.

The plan should include provision for everything from the educational campaign through a complete follow-up and report. Adequate records will be indispensable for final evaluation. Sample forms are now available from the Social Research Division of the National Tuberculosis Association.

A well worked-out plan for informing the whole community about the tuberculin testing program

is a necessity and also affords an opportunity to extend interest to the entire tuberculosis control effort. Expert guidance from professional health educators should be sought and represented on the central planning committee.

All reactors should have chest X-rays annually, although few white children up to age 12 will have demonstrable lesions. This may become more important if the use of chemotherapy for primary lesions becomes general. This preliminary X-ray check of reactors is only the first step in the follow-up program and will usually reveal few or no active cases.

The next and more difficult step is the examination by tuberculin test, X-ray, or both of all contacts of new reactors found. This is more successful among young children who have fewer contacts with adults and most of these are in the home. Practically, this search should be extended to reach the contacts of older children and adults who have recently become tuberculin reactors.

At present the available data are inconclusive both as to prevailing infection rates, trends in these rates, and the efficiency of various tuberculin testing programs in discovering new cases. Efforts are now being made to collect what information may exist but this has not so far been analyzed and reported. Plans for new studies are contemplated.

However, scattered reports provide a basis for some speculation: 1. Tuberculin infection rates are declining in most places. Reactor rates in schools and colleges are lower in recent years. 2. Infection rates vary considerably geographically and by age and sex. Rates are higher in more densely populated areas and increase up to age 60-70, although females have lower rates than males after age 30. After age 60-70 there is a decrease in reactor rates, but they remain high. There is some indication that new infection rates taper off rapidly after age 30-40 and that the high rates in the older ages are the result of high infection rates in the years when they are young. 3. Case-finding results using the tuberculin test as a preliminary screen are extremely variable but usually disappointing.

There are some theoretical reasons for the failure of tuberculin test programs to uncover larger numbers of previously unknown active cases: 1. In areas of low incidence and low prevalence of cases, factors at present not specifically identified, delay or prevent the development of infection into significant disease. 2. Well conducted health department programs with efficient continuous follow-up of old cases and new cases with their immediate contacts are already discovering most of the new and relapsing cases. 3. With the shift of average age of active cases to an older level, there is less likely to be a school age child in a home where a person with active tuberculosis resides. 4. Many children who live in a home with a tuberculosis patient do not become infected. 5. Many children are probably infected by casual contacts not easily traced.

Although the individual tuberculin test may seem inexpensive, the cost of a program can be very high for the results obtained in the control of tuberculosis. Material costs are low but all those tested must be seen at least twice by someone with professional training and a variable number will require subsequent X-ray examinations. The follow-up of contacts also requires large amounts of professional time and travel. Often the professional time is donated or hidden in the budget of another agency but it is a real cost and should be taken into account.

Although no one can place an absolute value on the benefit to the community in finding a case, the costs of a case-finding program must be weighed against other possible procedures which might be more efficient. A rational decision can only be made by a careful study in each community. Programs should be well planned with subsequent evaluation in mind.

Tuberculin tests are valuable in diagnosis, to determine the status of tuberculosis control in a community, and perhaps as a screening tool in case-finding. Although several techniques are in use, the intradermal test with P.P.D. is preferred. Patch tests can be used successfully but have definite disadvantages.

For determination of rates of infection and rate trends in a community, the best information can be obtained by testing the whole population. In decreasing order of efficiency, the test program may consist of a scientific sampling of the whole population, all school children and school employees, and selected school grades.

An important part of the preparation for a tuberculin test program which is valuable for both its immediate and long-range benefits is an extensive educational program for the whole community with as wide participation as possible.

The follow-up program is difficult and expensive. It must include examination of contacts of reactors as well as X-rays of reactors, and must be planned for in advance.

Accurate data on the case-finding potential of programs using the tuberculin test as a screen are almost totally lacking. Those who may have such data are urged to make them available through publication. Current tuberculin testing programs should be thoroughly evaluated and a few pilot studies should be initiated. Special assistance in planning such studies is now available through the NTA Division of Social Research.

Editor's Note: This is the second of two abstracts on the tuberculin test—the first of these was the April issue of Tuberculosis Abstracts.

**BUY
U. S. SAVINGS
BONDS**

INDEX

JOURNAL OF THE ARKANSAS MEDICAL SOCIETY

VOLUME LII

June, 1955 — May, 1956

ABBREVIATIONS—

(O) Original Article; (SP) Special Article;
(E) Editorial; (OB) Obituary; (R) Resolution.

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PERSONALS AND NEWS ITEMS

Gordon P. Oates and Edwin F. Gray, both of Little Rock, were delegates to the annual meeting of the Association of American Physicians and Surgeons at Columbus, Ohio, early in April.

Vincent O. Lesh and Ruth Ellis Lesh, Fayetteville, are spending a May vacation in Wisconsin.

Harvey Shipp, Little Rock, has been appointed Medical Director of the General Life Insurance Company of Arkansas.

L. H. McDaniel addressed the Rotary Club at Fayetteville on April 26. He also was guest speaker at the University of Arkansas Pre-med Club on the same date.

Blake Crow, Magnolia, addressed the Columbia County Tuberculosis Association in March at its annual meeting.

"Anesthesia" was the topic of Richard W. Hollis, of the State Sanatorium staff, who talked before the Booneville Rotary Club March 15.

C. H. Dickerson, Jr., Conway, is Staff Physician at the newly-opened Drake-Dickerson Clinic for the Treatment of Alcoholism.

Harry Murry, Texarkana, and Mrs. Murry have returned from a Post-Graduate Medical Tour of the Caribbean area. They were on the high seas for the month of March.

L. C. McVay, Marion, was honored recently with a lifetime membership in the Marion Masonic Lodge.

Ellery C. Gay, Little Rock, was appointed Director of the Crippled Children's Division of the State Welfare Department in April. This action replaced Frances Brennecke who is contesting the appointment.

K. M. Kretz announces the opening of his offices in Little Rock. His practice is limited to Obstetrics and Gynecology.

Alan G. Cazort of Little Rock was a guest speaker at the Louisiana State Medical Association annual meeting in Alexandria, Louisiana, on April 24. His subject was "Allergic Reactions to Common Drugs."

Registered at the meeting of the American Academy of General Practice in Washington in March were: Ben N. Saltzman, Mountain Home; O. H. Clopton, Rector; L. H. McDaniel, Tyronza; C. R. Ellis, Malvern; James M. Kolb, Clarksville; Fount Richardson, Fayetteville.

A. H. Hathcock, Fayetteville, attended the Southwestern Surgical Congress in Tucson in April.

PROCEEDINGS OF SOCIETIES

The second annual meeting of the Arkansas Medical Assistants Society was held in Little Rock April 14 and 15. Miss Charlene Hardeman of Little Rock presided. Arkansas physicians taking part in the program were Dale Alford and Joe F. Shuffield, Little Rock, and L. H. McDaniel, Tyronza.

Miss Eva Antonio, Hot Springs, was installed as president for the coming year.

J. H. McCurry was honored March 23 in his home town of Cash, with a Doctor's Day Program celebrating fifty-nine years of practice.

The Journal extends its own congratulations and opens its "Arkansas Traveling" column for a selection of his remarks, made on the occasion.

Franklin County physicians elected W. C. Hensley, Charleston, as president of the County Medical Society at its annual meeting in March. Other officers are: D. E. Brothers, vice president; D. L. Gibbons, secretary, and C. C. Long, delegate.

Sam G. Jameson, El Dorado, gave an address on "Pediatric Urology" at the Craighead-Poinsett County Medical Society in Jonesboro, on April 4.

Hot Springs was host early in March to a meeting sponsored by AMA's Committee on Maternal Welfare and Child Care. W. L. Crawford, Rockford, Illinois, Chairman, conducted the proceedings.

Other members of the Committee include Garland D. Murphy, Jr., of El Dorado; H. B. Mulholland of Charlottesville, Virginia; Phillip Barba of Philadelphia; Harold S. Morgan of Lincoln, Nebraska; J. L. Richards of Chicago; Howard A. Nelson of Greenwood, Mississippi; D. A. Duklow, Tom Hendricks, George A. Cooley, and Donald A. Byrd, all of Chicago, committee consultants.

Arkansas physicians who appeared on discussion panels were Calvin R. Simmons of Pine Bluff, Haynes Jackson of Hot Springs, and Willis E. Brown of the University of Arkansas School of Medicine at Little Rock.

A report of activities of the Arkansas Committee on Maternal and Child Care was given by Roger Bost of Fort Smith and Eva F. Dodge of Little Rock.

T. E. Williams was elected President of the Jackson County Medical Society at Newport where the annual meeting was held last month. Jabez Jackson is new vice president and J. D. Ashley was re-elected secretary and treasurer. Edward Novak, Tuckerman, is delegate to the Arkansas Medical Society and R. O. Norris, Tuckerman, is alternate.

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Pulaski County Medical Society met Wednesday, February 15, at 12:00 noon. Mrs. Thurston Black, chairman of Public Relations, was in charge. Speakers were Mr. Allen Weintraub, Administrative Assistant at St. Vincent's Hospital, and Dr. Delmar Goode, Manager of the V. A. Hospital. They discussed Public Relations in regard to a privately operated hospital and a government operated hospital. Hostesses were Mrs. H. W. Sterling, Mrs. J. F. Delaney, Mrs. H. G. Lonsdale and Mrs. Henry Hawkins.

1956-1957 officers of the Woman's Auxiliary to the Sebastian County Medical Society are: President, Mrs. L. A. Whittaker; vice president, Mrs. Wright Hawkins; secretary, Mrs. Art Martin; treasurer, Mrs. J. P. Shermer.

The Woman's Auxiliary to the Phillips County Medical Society has kept very busy this year.

They raised enough money with a benefit bridge to purchase a resuscitator for the hospital. A film fair touching on several subjects was held for the public. Limited space prevents me from explaining their Future Nurses Club set-up. But it is marvelous and most unique. 1956-1957 officers are: President, Mrs. H. B. Oldham; vice president, Mrs. George Gibbons; secretary-treasurer, Mrs. A. A. Berger; corresponding secretary, Mrs. Bernard Capes.

Mrs. Don Purcell of Paragould was elected president of the Greene-Clay County Medical Society Auxiliary at a tea held at the home of Mrs. Earle D. McKelvey. Mrs. Purcell succeeds Mrs. McKelvey.

Other new officers are: Mrs. H. R. Duckworth, Piggott, vice president, and Mrs. Alfred Maddox, Paragould, secretary-treasurer. Named to head committees were Mrs. Jacob Williams, Mrs. A. E. Andrews, Mrs. Robert Haley, Mrs. Clark Baker, Mrs. Robert Ratton and Mrs. McKelvey.

The group also mapped plans for "Doctor's Day," scheduled March 30.

The popular magazine, Woman's Home Companion, carried a brief but very interesting piece on Mona Lawson, president of the Woman's Auxiliary to the American Medical Association. The article, appearing in the April issue, was entitled: "She Speaks for 80,000 Doctors' Wives." It was a very laudatory story which called attention to the role of doctors' wives in promoting Medical Education Week, April 22-28.

The Southeastern Regional meeting of the Woman's Auxiliary to the Arkansas Medical Society was held at the Helena Country Club March 20, with Mrs. Wm. A. Ellis presiding.

Phillips County Auxiliary served as hostess. A coffee was held in the morning followed by the program. Luncheon was served at noon.

Those who attended this conference and served as guest speakers were: Mrs. John T. Gray of Jonesboro, state president; Mrs. J. W. Kennedy, Arkadelphia, first vice president; and Mrs. Paul Gray, Batesville, third vice president.

State Committee chairmen in attendance were Mrs. Ross Maynard and Mrs. Howard Stern of Pine Bluff, Mrs. Hoyt Choate, Mrs. V. T. Webb, Mrs. Estes Allen and Mrs. J. Harry Hayes of Little Rock.

Mrs. P. E. Terry and Mrs. Herd E. Stone came in from Holly Grove and Mrs. Dwight W. Gray was present from Marianna.

BOOK REVIEWS

Preventive Medicine in World War II. Vol. III. Personal Health Measures and Immunizations: John Boyd Coates, Jr., Col., M. C., U. S. Army. Director of Historical Unit, Office of the Surgeon General, Department of the Army. Pp. 394. Illustrated, 1955. U. S. Government Printing Office, Washington, D. C. \$3.25.

This third book of the complete series quotes problems, their solution, and the modus operandi of their resolution, from the top-level echelons of the medical service of the U. S. Army. Details are numerous, but there are statistical tables, as well as detailed results which give this volume some value, not only for history but to the present-day clinician. One can imagine this book as an invaluable text for younger men if we face another global conflict. The book is obviously edited for the record. However it provides a readable, reliable, and statistical source for the real student of preventative medicine.

Vascular Surgery: Surgery in World War II, Edited by Daniel C. Elkins, M.D., Professor of Surgery, Emory University of Georgia and Michael E. DeBakey, M.D., Professor of Surgery, Baylor University School of Medicine. Pp. 465. Buckram. Illustrated. 1955 Department of the Army, Surgeon General's Office. U. S. Government Printing Office. \$4.25.

Separate treatises on vascular surgery prior to World War II have been few. The designation of Vascular Surgery Centers during that period enabled the accumulation of considerable data and experience, from which some sound conclusions were deductible. This book is a report from these centers and records this accumulated experience. Its editors and compilers are surgeons of wide repute and teachers of considerable experience. While this volume is one of a series of the medical history of World War II, it will remain without doubt, as a foundation from which other texts are written as more experience is gained in the subject. The fundamentals of vascular surgery are not new Surgeon General George E. Armstrong advises us but he adds that, with this book, "Truly vascular surgery has come of age." Surgeons will find this book both interesting and instructive.

Diseases of the Chest. H. Corwin Hinshaw, M.D., Ph.D., Clinical Professor of Medicine, Stanford University School of Medicine, and L. Henry Garland, M.B., B.Ch., Clinical Professor of Radiology, Stanford University School of Medicine. Pp. 727; illustrated; W. B. Saunders Company, Philadelphia, 1956. \$15.00.

The practicing physician who has been out of medical school for more than 10 or 12 years will be surprised, on reading this book, to have it called a "text book." It serves well as a reference work to the background of the older texts on Physical Diagnosis, and on Diseases of the Chest, but it has encompassed new material for the present-day student.

This new material is presented chiefly by a correlation of X-ray findings in the clinical picture of each disease. Clinicians themselves have relied for more than a score of years on the assistance of the X-ray study, but this correlation has been perfected in the authors' new book, to a high degree.

Basic principles of the diagnosis of chest diseases are found clearly accented herein. The book leans heavily on the X-ray interpretations. Treatment is mentioned in most

types of disease, but, generally, the finer details of therapy are left for other authors. This is not true of the section on Tuberculosis, where treatment is well defined. The book is new. Its approach makes it almost as new to the older clinician as it is to the senior medical student.

It is concisely written with a brief bibliography given at chapter ends. Each chapter begins with an italicized summary, which facilitates its use as a reference work. The type is well chosen for easy reading, and the skill of the bookmaker is at its highest point in this volume.

Pathologic Physiology: Mechanisms of Disease. William A. Sodeman, M.D., F.A.C.P., Professor of Medicine and Chairman of the Department of Medicine, School of Medicine, University of Missouri, Columbia, Mo. 2nd Ed. Pp. 963. Illustrated. 1956. \$13.00. W. B. Saunders Company, Philadelphia.

In our day when it is highly important to differentiate organic from non-organic disease, Sodeman's second edition of Pathologic Physiology brings up to date information on disease processes that are not particularly manifested by anatomic changes. Nonetheless these are alterations from normal just as surely as those that have been time tested by their anatomic alterations.

Part VI on the circulatory system including Hemodynamics is an important piece of reference due to the tremendous advances in therapeutic procedures concerning this system within the last decade.

The electrocardiogram, as presented by F. D. Johnston, brings a practical method of interpretation without getting lost in vast volume of physics.

You will read Pathologic Physiology with a great deal of interest as it presents the importance of detecting alterations in physiologic processes as well as those of anatomic character. The practice of medicine in the future cannot possibly be based on anatomic changes alone and it is important for the modern physician to keep abreast of these recent trends which deal with disease at the onset instead of the late stages which result in anatomic alterations.


Charles A. Taylor.



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